

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2260

CERTIFICATE OF DEATH

02221

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Crownsville</u>		<u>7 yrs. 2 mos. 4 days</u>		TOWN <u>Baltimore City</u>		<u>3/21-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>West Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>James</u> <u>Alton</u>				<u>3</u> <u>21</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Negro</u>	<u>Unk.</u>	<u>1870 ?</u>	<u>84 ?</u> yrs.	Months <u>-</u> Days <u>-</u>	Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Unknown</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward Alton</u>				<u>Mary Elizabeth Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>4</u> <u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>1/21/55</u> to <u>3/21/55</u> that I last saw the deceased <u>alive on</u> <u>3/21/55</u> and that death occurred at <u>11:00 p.m.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>L. Benedict, M. D.</u>		<u>Crownsville, Md.</u>		<u>3/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>3/28/55</u>		<u>Crownsville State Hospital</u>		<u>Crownsville, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Mar 28 55</u>		<u>[Signature]</u>		<u>Arnold H. Eicher</u>		<u>Crownsville, Md.</u>	

CERTIFICATE OF DEATH

2280

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1955

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CLERK

13. SIGNATURE OF DECEASED

14. SIGNATURE OF SURVIVORS

15. SIGNATURE OF OTHERS

BUREAU V. S.

MAR 30 1955

RECEIVED

1955

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2261
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02222/
Reg. Dist. No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		22 yrs. 10 mos.		TOWN <u>Ridgeley</u>		05X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural, give location) <u>None listed</u>			
3. NAME OF DECEASED: (First) <u>Ethel</u>		(Middle)		(Last) <u>Armstrong</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>2</u> (Year) <u>19 55</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>1905?</u>	
9. AGE last birthday: <u>49?</u> yrs.		IF UNDER 1 YEAR: Months		IF UNDER 24 HRS. Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>- - -</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME: <u>Fred Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown Mary Hubbard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		(If Yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Acute Cardiac Failure</u>						3 days	
DUE TO							
Antecedent cause(s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E. Hubbard</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/2/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>3/5/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Union</u>		LOCATION (City, town, or county) (State): <u>Goldboro, Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-3-55</u>		REGISTRAR'S SIGNATURE: <u>H. M. Jones</u>		24. FUNERAL DIRECTOR: <u>J. E. Bouleau</u> ADDRESS: <u>Greenboro, Md.</u>			

RECEIVED

MAR 8 1955

BUREAU V. S.

2262

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>AAC</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>AAC</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>MILLERSVILLE</u>	<u>3 MO</u>	TOWN <u>BROOKLYN PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>90 SAHN'S NURSING HOME</u>		<u>6020 LITCHFIELD HGV</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>RAYMOND</u> <u>ARNOLD</u>		OF DEATH: <u>Mar</u> <u>9</u> <u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>M</u>	<u>W</u>	<u>SINGLE</u>	<u>SEPT. 14, 1878</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>76</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Unknown</u>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>MARYLAND</u>			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<u>9</u>			
17. INFORMANT & ADDRESS:			
<u>MRS. E. AUSTIN 6020 LITCHFIELD HGV</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>		<u>+ 3 months</u>	
ANTECEDENT CAUSE (S) (B) <u>Chronic Interstitial Nephritis</u>		<u>+ 3 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 20</u> , 19 <u>50</u> , to <u>March 9</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>March 8</u> , 19 <u>55</u> , and that death occurred at <u>8:45</u> A. M. from the causes and on the date stated above.			
SIGNATURE <u>Robert H. Bunker</u>		DATE SIGNED <u>3/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>St. Paul's Cemetery Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>3-10-55</u>		<u>Wm. Cook Inc., 1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

STATE OF NEW YORK

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2237

02225

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63</u> <u>ANNE ARUNDEL GENERAL HOSPITAL</u>				STREET ADDRESS <u>22 BLOOMSBURY SQUARE</u>			
3. NAME OF DECEASED (First) <u>RUBY</u> (Middle) <u>E</u> (Last) <u>BASSFORD</u>				4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>19</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 2, 1901</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO. <u>215-305703</u>		17. INFORMANT & ADDRESS <u>MR GEORGE C. BASSFORD* Husband-same as #2</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199.9 IMMEDIATE CAUSE (A) <u>Pneumothorax (pleural a?)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatosis</u>						<u>7 mon</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0 -</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office-bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July, 19 54</u> , to <u>3/19/19 55</u> , that I last saw the deceased alive on <u>3/19/19 55</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shupley</u>		DATE THEREOF <u>March 21, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24. REC'D BY REGISTRAR DATE <u>March 21, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	

BUREAU V. S.

1

INSTRUCTIONS

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V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2238

CERTIFICATE OF DEATH

02226

Reg. Dist. No. 21

Item 7, Film G179 4-7-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) Annapolis		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Green Haven, PASADENA, Md.		OR TOWN X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General				STREET ADDRESS Outing Ave. & 2nd St.		1	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) John (none) Bialozynski				4. DATE OF DEATH (Month) (Day) (Year) March 27, 19 55			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Unknown	9. AGE last birthday 68? yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		10b. KIND OF BUSINESS OR INDUSTRY Home Improvement		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Bialozynski				14. MOTHER'S MAIDEN NAME Josephine Prosinska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Mrs. Martin Sass Camp Meade Rd.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						4 HOURS	
420.0 IMMEDIATE CAUSE (A) Pulmonary Edema							
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Arteriosclerotic Heart Disease						unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/27 , 19 55 , to 3/27 , 19 55 , that I last saw the deceased alive on 3/27 , 19 55 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.							
SIGNATURE Edward A. Beck				ADDRESS (Street, city, town, state) 4 Southgate Ave, Annapolis 32815		DATE SIGNED 3/28/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 1, 1955		NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
24. REC'D BY REGISTRAR 4/1/55		REGISTRAR'S SIGNATURE Wm. J. French		25. FUNERAL DIRECTOR'S SIGNATURE George Horne		ADDRESS 4001 Ritchie Hgwy.	

CERTIFICATE OF DEATH

3238

NAME OF DECEASED

ANNE ARNOLD

DATE OF DEATH

APRIL 11, 1938

PLACE OF DEATH

1000 BAYVIEW, BALTIMORE, MD.

ON THE 11th DAY OF APRIL, 1938

DEATH REPORTED BY

DR. J. H. HARRIS

(NAME)

JOHN

WHITE

MALE

CAUSE OF DEATH

HEART DISEASE

BUREAU V. S.

APR 1

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

2263

MARYLAND STATE DEPARTMENT OF HEALTH

02227

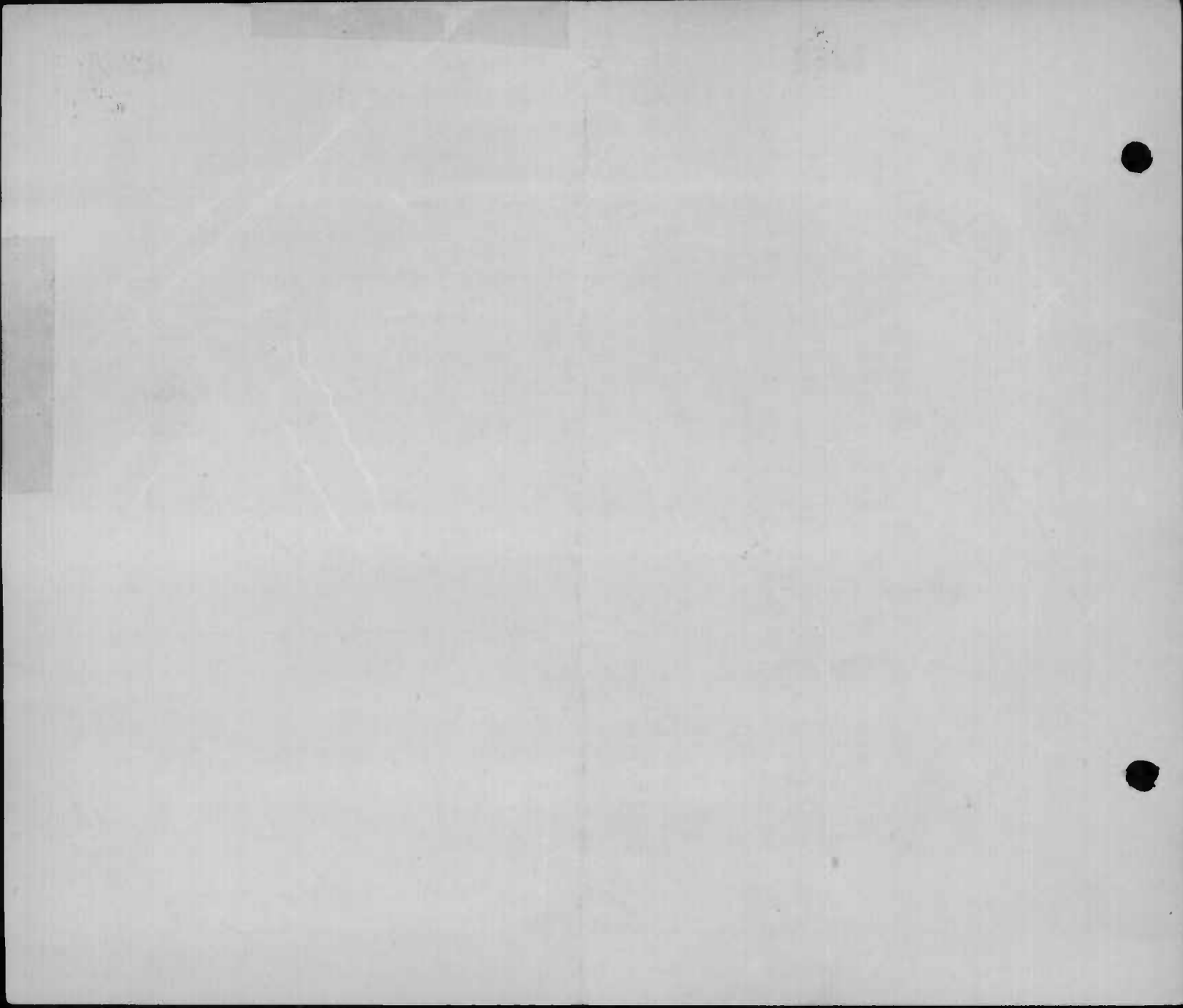
CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE _____ COUNTY _____			
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>P.O. Glen Burnie</u> LENGTH OF STAY (In this place) <u>4 years</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN _____			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Point Pleasant</u>				STREET ADDRESS (If rural, give location) <u>Laurel</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Charles A.</u> (Middle) _____ (Last) <u>Boone Jr.</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u> (Specify) <u>Married</u>		8. DATE OF BIRTH <u>7/5/07</u>	
9. AGE last birthday <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician for telephone lines, retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A. Boone</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____				16. SOCIAL SECURITY No. <u>218-09-8184</u>		17. INFORMANT AND ADDRESS <u>Mrs. M. Boone (Wife)</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>420.1 Immediate cause (a) <u>Coronary Occlusion</u> Interval Between Onset and Death <u>Sudden</u></p> <p>Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____</p>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____							
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION _____			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>				23. FUNERAL CREMATION REMOVED (Specify) <u>Burial</u> DATE THEREOF <u>3/30/55</u> NAME OF CEMETERY OR CREMATORY <u>Landon Pk.</u> LOCATION (City, town, or county) <u>Balto. 17, Md.</u> (State) _____			
24. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>				25. FUNERAL DIRECTOR <u>Wm. J. Vickner & Sons, Balto</u> ADDRESS <u>17, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this, certificate has been executed by the attending physician, and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2239

CERTIFICATE OF DEATH

02228

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>				TOWN <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>104 MARKET</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>EDWIN</u> (Last) <u>BRENNEMAN</u>				(Month) <u>3</u> (Day) <u>10</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>1-17-1881</u>	<u>74</u> Yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>CLERK</u>			<u>U.S. NAVAL ACADEMY</u>	<u>PA</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>DAVID ALBERT BRENNEMAN</u>				<u>JANE SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>CYNTHIA M. BRENNEMAN</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED White at work Not while at work		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>10 Mar</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10 Mar</u> , 19 <u>55</u> , and that death occurred at <u>5:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Edward A. Beck</u>				<u>4 Southgate Ave Annapolis</u>		<u>3-10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>3-14-55</u>		<u>New Harmony Cent</u>	
24. REC'D BY REGISTRAR				RECEIVED SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>March 11, 1955</u>				<u>J. J. Daniel</u>		<u>John W. Taylor Sons Annapolis Md.</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2264 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02229

CERTIFICATE OF DEATH

Reg. Dist. No. 22

Item 12. Film C180 4-15-55 et

1. PLACE OF DEATH COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Jessup		MARYLAND LENGTH OF STAY (in this place) 6 1/2 months		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Stockton, Md. COUNTY Worcester CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 238-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maryland House of Correction		STREET ADDRESS (If rural, give location) Jessup, Maryland			
3. NAME OF DECEASED (Type or Print) Charles		(First) Charles (Middle) Brown (Last) Brown		4. DATE OF DEATH (Month) (Day) (Year) March 7th. 1955	
5. SEX male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Dec. 25, 1900	9. AGE last birthday 54 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chile	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War I		16. SOCIAL SECURITY NO. I		17. INFORMANT AND ADDRESS Md. House of Correction	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
151X Immediate cause (a) Carcinoma of Stomach with metastases					6-12 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-15 , 19 54 , to 3-7 , 19 55 , that I last saw the deceased alive on 3-6 , 19 55 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above.					
SIGNATURE Robert B. Taylor MD		(Degree or title)		ADDRESS Maryland House of Correction, Md.	
23. BURIAL OR CREMATION (Specify) Burial		DATE THEREOF 3/16/55		NAME OF CEMETERY OR CREMATORY Trinity	
LOCATION (City, town, or county) (State) Baltimore, Md.		DATE RECD BY LOCAL REG. 3/16/55		REGISTRAR'S SIGNATURE Charles H. Smith	
M. FUNERAL DIRECTOR Mrs. F. H. Hensley		ADDRESS 378 W. Biddle St.			

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02230

2265 CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL OR and give nearest town), TOWN <u>Crownsville</u>				STATE <u>Maryland</u> COUNTY <u>Caroline</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Greensboro</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>None listed</u>			
3. NAME OF DECEASED (Type or Print) <u>Dennis</u> (First) <u>Brown</u> (Last)				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>8</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>3/4/1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> - - - - - </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>219-14-4906</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u> - - - - - </u>			19b. MAJOR FINDINGS OF OPERATION <u> - - - - - </u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> - - - - - </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> - - - - - </u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u> - - - - - </u>			21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work el work		21f. HOW DID INJURY OCCUR? <u> - - - - - </u>		
22. I hereby certify that I attended the deceased from <u>5/29/</u> , 19 <u>54</u> , to <u>3/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>55</u> , and that death occurred at <u>(L. Benedict)</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/12/55</u>	NAME OF CEMETERY OR CREMATORY <u>Union</u>		LOCATION (City, town, or county) (State) <u>Goldsboro Md.</u>		
24. REC'D BY REGISTRAR <u> - - - - - </u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Boulain</u>			
DATE <u>3-12-55</u>		REGISTRAR'S ADDRESS <u> - - - - - </u>		FUNERAL DIRECTOR'S ADDRESS <u>Greensboro, Md.</u>			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2266

CERTIFICATE OF DEATH

02231

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MD</u> COUNTY <u>AA</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Shady Side</u>		LENGTH OF STAY (in this place) <u>25 yrs</u>		TOWN <u>Shady Side</u>		TOWN <u>Shady Side</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Thomas Busser</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3rd 5th 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>MAY 4 1896</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>Churchton</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert H. Bussey</u>				14. MOTHER'S MAIDEN NAME <u>Queenie Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Katherine F. Schmick</u> <u>ARNOLD MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
150x IMMEDIATE CAUSE (A) <u>Hemorrhage - esophageal</u>						<u>18 Hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma - esophagus</u>						<u>6 Mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-14</u> , 19 <u>54</u> , to <u>3-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-4</u> , 19 <u>55</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. <u>3-5-55</u>							
SIGNATURE <u>Dr. Hendricks</u>		M.D. <u>Shady Side, Maryland</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>200ker</u>		LOCATION (City, town, or county) (State) <u>Walesville MD</u>	
24. REC'D BY REGISTRAR <u>Mar. 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Ida Belle Dent</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Walesville, Md</u>	

BUREAU V. S.

MAR 10 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2267

CERTIFICATE OF DEATH

02232

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		<u>3/01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>439 W. Henrietta Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Frances</u> (Last) <u>Carr</u>				(Month) <u>3</u> (Day) <u>5</u> (Year) <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1884?</u>	9. AGE last birthday <u>71?</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>600.0</u> IMMEDIATE CAUSE (A) <u>Uremia</u>				Known to us since <u>3/3/55</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Chronic Pyonephrosis</u>				"			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Gangrenous urinary cystitis</u>				"			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Brain Disease</u>				"			
19a. DATE OF OPERATION <u>2</u> - - -		19b. MAJOR FINDINGS OF OPERATION <u>- - - - -</u>		2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>3/5</u> 55		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/3</u> , 19 <u>55</u> , to <u>3/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>55</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict</u>		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>3/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>3/9/55</u>		REGISTRAR'S SIGNATURE <u>R. W. Benedict</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. [Signature]</u>		ADDRESS <u>661 W. [Signature]</u>	

CERTIFICATE OF DEATH

1933

File No. 10

1. FULL NAME OF DECEASED

2. SEX ☐ MALE ☐ FEMALE

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF MINISTER

15. SIGNATURE OF CHURCH

16. SIGNATURE OF FAMILY

17. SIGNATURE OF NEAREST RELATIVE

18. SIGNATURE OF FRIEND

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

BUREAU V. 1

MAR 11 1933

RECEIVED

NOTES: This certificate is to be filled out by the physician or other person who has attended the deceased. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the Department of Health. The certificate should be filled out in duplicate, and the original should be filed in the office of the Registrar, and the duplicate should be sent to the funeral home. The certificate should be filled out in duplicate, and the original should be filed in the office of the Registrar, and the duplicate should be sent to the funeral home. The certificate should be filled out in duplicate, and the original should be filed in the office of the Registrar, and the duplicate should be sent to the funeral home.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2240

CERTIFICATE OF DEATH

02233

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anna Arundel		MARYLAND		STATE Md.		COUNTY Baltimore,	
CITY (If outside corporate limits, write RURAL and give nearest town) 10 TOWN Annapolis,		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riderwood,		03X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 Anna Arundel General Hospital				STREET ADDRESS (If rural give location) W. Joppa Road			
3. NAME OF DECEASED (Type or Print) Stuart M. Christhlf				4. DATE OF DEATH (Month) (Day) (Year) March 16, 19 55			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Nov. 4, 1889	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distributor - Construction & Industrial		10b. KIND OF BUSINESS OR INDUSTRY Equipment		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry B. Christhlf				14. MOTHER'S MAIDEN NAME Anna M. O. Gill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) 9		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS 1708 Circle Road Mr. Bryson Christhlf Ruxton-4, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) Rupture of dissecting aortic aneurysm							
ANTECEDENT CAUSE(S) DUE TO (B) atherosclerosis of aorta						5 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic-Hypertensive CVD						5 yr.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 2		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/12/55, to 3/16/55, that I last saw the deceased alive on 3/16/55, and that death occurred at 3:25 P.M. from the causes and on the date stated above.							
SIGNATURE Frank McElroy				ADDRESS (Street, city, town, state) M.D. Annapolis Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF March 19, 1955		NAME OF CEMETERY OR CREMATORY Druid Ridge	
24. REC'D BY REGISTRAR DATE 3/21/55				REGISTRAR'S SIGNATURE John O. Mitchell		25. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons	
				LOCATION (City, town, or county) Pikesville,		ADDRESS 1900 Rutaw Place	

15823

CERTIFICATE OF DEATH

For Use by

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. DATE OF ENTRY

13. TIME OF ENTRY

14. PLACE OF ENTRY

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF CLERK

18. SIGNATURE OF DECEASED

19. SIGNATURE OF CLERK

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESSES

22. SIGNATURE OF CLERK

23. SIGNATURE OF DECEASED

24. SIGNATURE OF CLERK

25. SIGNATURE OF DECEASED

26. SIGNATURE OF CLERK

27. SIGNATURE OF DECEASED

28. SIGNATURE OF CLERK

29. SIGNATURE OF DECEASED

30. SIGNATURE OF CLERK

31. SIGNATURE OF DECEASED

32. SIGNATURE OF CLERK

33. SIGNATURE OF DECEASED

34. SIGNATURE OF CLERK

35. SIGNATURE OF DECEASED

36. SIGNATURE OF CLERK

37. SIGNATURE OF DECEASED

38. SIGNATURE OF CLERK

39. SIGNATURE OF DECEASED

40. SIGNATURE OF CLERK

41. SIGNATURE OF DECEASED

42. SIGNATURE OF CLERK

43. SIGNATURE OF DECEASED

44. SIGNATURE OF CLERK

45. SIGNATURE OF DECEASED

46. SIGNATURE OF CLERK

47. SIGNATURE OF DECEASED

48. SIGNATURE OF CLERK

49. SIGNATURE OF DECEASED

50. SIGNATURE OF CLERK

BUREAU V.S.

MAR 22 1917

RECEIVED

MAR 10 1917

MAR 10 1917

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2268 **CERTIFICATE OF DEATH**

02234

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>POWHATAN BEACH</u>		LENGTH OF STAY (in this place) <u>6 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>POWHATAN BEACH</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. 3 PASEDENA</u>				STREET ADDRESS (If rural give location) <u>R.F.D. 3 PASEDENA</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HOMER BUTTS CLARK</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 2 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Feb. 19, 1877</u>		9. AGE last birthday <u>78</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSIT CO.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARK</u>				14. MOTHER'S MAIDEN NAME <u>Judith Hammond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Thomas H. Clark 7517 BELAIR Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.0 MYOCARDIAL INFARCTION</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) (B) <u>DUE TO ARTERIOSCLEROTIC HEART DISEASE 2 years</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:55 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Lois Taler</u>		M.D. <u>102 BALTO-ANNAP. BLVD. GLEN BURNIE N.E., Md.</u>		DATE SIGNED <u>3/2/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
24. REG'D BY REGISTRAR <u>Mar. 8, 1955</u>		REGISTRAR'S SIGNATURE <u>Louis J. DeBaltis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schmitt</u>		ADDRESS <u>2108 Frederick Ave.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

2. DEATH PLACE (HOSPITAL, HOME, OR OTHER)

MARYLAND

3. PLACE OF DEATH

DATE

TIME

DEATH

CAUSE

AGE

SEX

DATE

CLERK

NAME

RESIDENCE

1. DEATH CERTIFICATE

2. DEATH CERTIFICATE

3. DEATH CERTIFICATE

4. DEATH CERTIFICATE

5. DEATH CERTIFICATE

6. DEATH CERTIFICATE

7. DEATH CERTIFICATE

8. DEATH CERTIFICATE

9. DEATH CERTIFICATE

10. DEATH CERTIFICATE

11. DEATH CERTIFICATE

12. DEATH CERTIFICATE

13. DEATH CERTIFICATE

14. DEATH CERTIFICATE

15. DEATH CERTIFICATE

RECEIVED

BUREAU X. 1

1955

MAR 3

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2269

02235
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>A.A. Co.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A.A. Co.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>TOWN Mayo</u>				<u>TOWN Mayo, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Mayo, Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)			
<u>KARLINE OBERG COLLISON</u>		<u>3</u>		<u>7</u>		<u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Married</u>	<u>3/4/1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Home</u>		<u>Housewife</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Wesley Dawson</u>				<u>Josephine Oberg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>9</u>				<u>Harry Collison #2</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Carotid Artery Disease</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Seven</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>0</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>[Signature]</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>3/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/10/55</u>		<u>Mayo Memorial</u>		<u>Mayo Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 9, 1955</u>		<u>Edward Collison</u>		<u>John M. Taylor and Sons</u>		<u>Annapolis, Md.</u>	

BUREAU V. 3

MAR 14 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2270

CERTIFICATE OF DEATH

02236

Reg. Dist. No. *24*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>A.A.</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>A.A.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>X</i> TOWN <i>Pt. Pleasant</i>				OR TOWN <i>Pt. Pleasant</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>00</i>				<i>1</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Barbara Mary Cunningham</i>				<i>3</i> <i>3</i> <i>55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>F</i>	<i>W</i>	<i>M</i>	<i>12/22/90</i>	<i>64</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housework</i>		<i>Home</i>		<i>Baltimore</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Michael J. Zant</i>				<i>Barbara M. Wise</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>				<i>Family - Same</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<i>153X</i> IMMEDIATE CAUSE (A) <i>Carcinoma tosis</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Carcinoma Colon</i>						<i>1 year</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<i>0</i>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct Mar, 1954</i>, to <i>March, 1955</i>, that I last saw the deceased alive on <i>2-26</i>, 19 <i>55</i>, and that death occurred at <i>3:30</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>B Mac Donald</i>				M. D. <i>Edna Burnie Md</i>		DATE SIGNED <i>3-3-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>B</i>		<i>3/8/55</i>		<i>Cathedral</i>		<i>Baltimore Md.</i>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>Mar. 7, 1955</i>		<i>L. J. Sealy</i>		<i>James L. McCully - 130 E. Fort Ave.</i>			

12232

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

2270

1. PLACE OF DEATH

CITY

COUNTY

STATE

ZIP

DATE

TIME

CAUSE

ICD-9

ICD-10

ICD-11

ICD-12

ICD-13

ICD-14

ICD-15

ICD-16

ICD-17

ICD-18

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2271

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Capt 1-Bn 194 Millersville 15 mos.</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Capt 1-Bn 194 Millersville P.O.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>P.O. Rd</i>		STREET ADDRESS (If rural give location)	<i>X</i>
3. NAME OF DECEASED: (Type or Print) <i>Agnes (First) MATILDA (Middle) DAIL (Last)</i>		4. DATE OF DEATH: (Month) (Day) (Year) <i>MARCH 15 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married June 3, 1898</i>	8. DATE OF BIRTH: <i>5-6</i>
9. AGE last birthday: <i>56</i> yrs.		10. IF UNDER 1 YEAR: <i>Months</i> <i>Days</i> <i>Hours</i> <i>Min.</i>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>See 10a</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>3 No</i>		16. SOCIAL SECURITY No.: <i>215-14-8517</i>	
17. INFORMANT & ADDRESS: <i>Howard Dail Jr. Address - Same</i>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
<i>260X Immediate cause</i>		<i>3 hrs</i>	
(a) <i>Pulmonary Edema</i>			
DUE TO			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		<i>5 yrs.</i>	
(b) <i>Diabetes Mellitus</i>			
DUE TO			
(c) <i>Essential Hypertension</i>		<i>3 yrs</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<i>15 yrs</i>	
<i>Obesity</i>			
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <i>Yes</i> <input type="checkbox"/> <i>No</i> <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
	OF INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?	
	m.		
22. I hereby certify that I attended the deceased from <i>3/15</i> , 19 <i>55</i> to <i>3/15</i> , 19 <i>55</i> that I last saw the deceased alive on <i>3/15</i> , 19 <i>55</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.			
SIGNATURE (Degree or title) <i>Dr. Richard M. D. Conburne Md</i>		DATE SIGNED <i>3/15-1955</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	DATE THEREOF <i>3/18/55</i>	NAME OF CEMETERY OR CREMATORY <i>Old Home Private Cemetery</i>	LOCATION (City, town, or county) <i>Wilson's Dam Old Town</i>
DATE REC'D BY LOCAL REGISTRAR <i>March 17, 1955</i>	REGISTRAR'S SIGNATURE <i>L. J. Deleba</i>	24. FUNERAL DIRECTOR <i>Wilmington</i>	ADDRESS <i>Ben Burnie</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 21 1965

BUREAU V. S.

2241

MARYLAND STATE DEPARTMENT OF HEALTH

02238

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Linden</u> 15X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Richard</u> (Middle) <u>Ralph</u> (Last) <u>Davis</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>24</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>M</u>	8. DATE OF BIRTH <u>Sept. 23, 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>40</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ulysses Brown</u>		14. MOTHER'S MAIDEN NAME <u>Georganna Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Elizabeth Davis - Linden, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
910.5 Immediate cause (a) <u>Fracture Cervical Vert. C Compression</u>		
Antecedent cause(s) (b) <u>of Claud</u>		<u>Sudden</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Highway</u>	(CITY OR TOWN) <u>02</u> (COUNTY) <u>A.A.C.O.</u> (STATE) <u>MD.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3</u> <u>24</u> <u>55</u> P. m.	INJURY OCCURRED While at <input checked="" type="checkbox"/> work Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Free fall over Patient</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>John L. Ladd</u>	(Degree & title) <u>MD</u>	ADDRESS <u>Annapolis, Maryland</u>	DATE SIGNED <u>3/24/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-28-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Hall</u>	LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
DATE REC'D BY LOCAL REG. <u>March 25, 1955</u>	REGISTRAR'S SIGNATURE <u>J. O. Brown</u>	24. FUNERAL DIRECTOR <u>William Reese, Jr.</u>	ADDRESS <u>108 Washington St. Annapolis, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 28 1971

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02239

2272

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AnneArundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>4yrs.7mos.5days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1713 Pierce Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Emma</u> (First) (Middle) (Last) <u>Derricks</u>				4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>9/11/04</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Epilepsy</u>						Known to us since <u>7/26/50</u>	
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION <u>- - - - -</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>- - - - -</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- - - - -</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>- - - - -</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>- - - - -</u>			
22. I hereby certify that I attended the deceased from <u>7/26</u> , 19 <u>50</u> , to <u>3/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/3</u> , 19 <u>55</u> , and that death occurred at <u>1:10p.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem</u>		LOCATION (City, town, or county) (State) <u>Balto. Co. Md</u>	
24. REC'D BY REGISTRAR <u>3-8-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Balto.</u>	

CERTIFICATE OF DEATH

2273

MASSACHUSETTS DEPARTMENT OF HEALTH

1935

BUREAU V. S.

MAR 8 1935

RECEIVED

WILLIAM CARDON

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2273

CERTIFICATE OF DEATH

02240

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>24 days</u>		TOWN <u>Rhodesdale</u>		<u>09X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>R. F. D.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Parley</u>		(Middle) <u>L.</u>		(Last) <u>Dockins</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>11/4/95</u>	
9. AGE last birthday <u>59</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months <u>3</u> Days <u>6</u>		Hours <u>19</u> Min. <u>55</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Moses Ferrell</u>				14. MOTHER'S MAIDEN NAME <u>Alonza Ferrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				Known to us since <u>2/10/55</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension and Arteriosclerotic cardiovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>			
21d. TIME OF INJURY (Month) <u>---</u> (Day) <u>---</u> (Year) <u>---</u> (Hour) <u>---</u> (Min.) <u>---</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>55</u> , to <u>3/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/6</u> , 19 <u>55</u> , and that death occurred at <u>12:20 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>3/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>3/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>Thompsonstown Cemetery</u>		LOCATION (City, town, or county) (State) <u>Thompsonstown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>3-7-55</u>							

STATE CERTIFICATE OF DEATH

BUREAU V. S.

MAR 16 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02242

2274

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Winchester</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Winchester</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Carrie</i> (Middle) <i>Bersch</i> (Last) <i>Fischer</i>		(Month) <i>3</i> (Day) <i>12</i> (Year) <i>1955</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Nov. 26, 1867</i>
9. AGE last birthday <i>87</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Carl Bersch</i>	
14. MOTHER'S MAIDEN NAME <i>Angelica Bode</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mrs. Gerda Vey #2</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <i>Embolism to brain, rt. hand & leg</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic CVD</i>		<i>yr.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan</i> , 19 <i>55</i> , to <i>3/12</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>3/12</i> , 19 <i>55</i> , and that death occurred at <i>8:08 P.</i> M. from the causes and on the date stated above.			
SIGNATURE <i>Frank M. Shuply</i>		DATE SIGNED <i>3/14/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>Presbyterian Cent</i>	
DATE THEREOF <i>3-16-55</i>		LOCATION (City, town, or county) (State) <i>Groves Balto Md</i>	
24. REC'D BY REGISTRAR DATE <i>March 14, 1955</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>	
REGISTRAR'S SIGNATURE <i>J. O. Daniel</i>		ADDRESS <i>Sons Annapolis Md</i>	

2271 CERTIFICATE OF DEATH

Reg. Dist. No.

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CONSTABLE

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF COUNTY

20. SIGNATURE OF STATE

21. SIGNATURE OF UNION

22. SIGNATURE OF WORLD

23. SIGNATURE OF FUTURE

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26. SIGNATURE OF MIDDLE

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2275

02243

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY OR TOWN <u>Nutwell</u>		LENGTH OF STAY (in this place) <u>63 yrs</u>		CITY OR TOWN <u>Nutwell</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Thomas Luther Ford</u>				4. DATE OF DEATH <u>MAR 11</u> 19 <u>55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>OCT 13 1871</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		9. AGE last birthday <u>83</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>TRACYS MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert Ford</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Susie R Ford, Nutwell, MD</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, C.V.R. disease</u>						<u>unk</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>260X</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>						8 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1955</u> , to <u>Mar 11 1955</u> , that I last saw the deceased alive on <u>Mar 5 1955</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W.B. Danner</u>				ADDRESS (Street, city, town, state) <u>Upper Marlboro Md 20788</u>			
DATE THEREOF <u>3/13/55</u>				NAME OF CEMETERY OR CREMATORY <u>Friendship</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				LOCATION (City, town, or county) (State) <u>Friendship MD</u>			
24. REC'D BY REGISTRAR <u>Chris Ann Williams</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Harduty</u>			
DATE <u>3/12/55</u>				ADDRESS <u>Galesville Md</u>			

1. This form is to be filled out by the attending physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and before the body is moved or buried. It should be filled out in the presence of the coroner or other official who is in charge of the investigation. It should be filled out in the presence of the family or other persons who are present at the death. It should be filled out in the presence of the coroner or other official who is in charge of the investigation. It should be filled out in the presence of the family or other persons who are present at the death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

5255

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF CORONER

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF BURIAL

13. SIGNATURE OF CREMATION

14. SIGNATURE OF OTHER

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

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RECEIVED
MAR 15 1955
BUREAU V. I.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2276

02244

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Q. A.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>NAVA</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HILLSMEER STONES</u> <u>X</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 RIVA CONVALESCENCE HOME</u>				STREET ADDRESS (If rural give location) <u>ANNAPOLIS R.F.D. MD 1</u>			
3. NAME OF DECEASED (Type or Print) <u>SADIE</u> (First) <u>K.</u> (Middle) <u>FULTON</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>3-30</u> 19 <u>55</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOW</u>	8. DATE OF BIRTH <u>5-13-1867</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PITTSBURGH PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY P. KREBS</u>				14. MOTHER'S MAIDEN NAME <u>SARAH PALMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Morris Knowles</u> <u>Peach Drive</u> <u>Baltimore Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>gen arteriosclerosis</u>				<u>5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/19</u> , 19 <u>55</u> , to <u>3/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>55</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. Brown</u>		M.D.		ADDRESS (Street, city, town, state) <u>Annapolis Md</u>		DATE SIGNED <u>3/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3-31-55</u>		NAME OF CEMETERY OR CREMATORY <u>Pittsburgh Pa</u>		LOCATION (City, town, or county) (State) <u>Pa</u>	
24. REC'D BY REGISTRAR <u>Edw. G. Collinson</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lay</u>		ADDRESS <u>Laurel Annapolis Md</u>	
DATE <u>March 31, 1955</u>							

03344

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

3278 CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF CORONER

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CLERK OF COURT

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF DEPUTY SHERIFF

23. SIGNATURE OF CLERK OF COURT

24. SIGNATURE OF JURY

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47. SIGNATURE OF DEPUTY SHERIFF

48. SIGNATURE OF CLERK OF COURT

49. SIGNATURE OF JURY

50. SIGNATURE OF JUDGE

BUREAU V. S.

APR 5 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2277

CERTIFICATE OF DEATH

02245

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>4 mos. 8 days</u>		TOWN <u>Baltimore City</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>652 W. Franklin Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Leetta Evelyn Gibbs</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 24 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>8/15/11</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Mack Preston</u>				14. MOTHER'S MAIDEN NAME <u>Rosetta Ealy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>782.4</u> IMMEDIATE CAUSE (A) <u>Acute heart failure</u>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/16</u> , 19 <u>54</u> , to <u>3/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/24</u> , 19 <u>55</u> , and that death occurred at <u>5:30a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict</u>		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
24. REC'D BY REGISTRAR <u>3/28/55</u>		REGISTRAR'S SIGNATURE <u>Lathrine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. Hallock</u>		ADDRESS <u>1918 Danvers Rd. Me</u>	

100-100000

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Med. Dept. 100

1. Name of deceased

2. Sex

3. Date of birth

4. Date of death

5. Place of death

6. Cause of death

7. Signature

8. Medical history

9. Description of disease

10. Signature of physician

11. Signature of coroner

12. Signature of registrar

13. Signature of witness

14. Signature of family

BUREAU V. 2

MAR 28 1955

RECEIVED

1. Name of deceased
2. Sex
3. Date of birth
4. Date of death
5. Place of death
6. Cause of death
7. Signature
8. Medical history
9. Description of disease
10. Signature of physician
11. Signature of coroner
12. Signature of registrar
13. Signature of witness
14. Signature of family

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2278

CERTIFICATE OF DEATH

02246

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1810 Etting St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Annie Gray</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 26</u> 19 <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>10/12/78</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unk</u>				14. MOTHER'S MAIDEN NAME <u>unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital Record</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident (Hemorrhage)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive & Arteriosclerotic Cardiovascular D's.</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized & Cerebral Arteriosclerosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>2/16/55</u> , 19 <u>55</u> , to <u>3/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>55</u> , and that death occurred at <u>6:30 a</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stanley A. Sargent</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar 30/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore</u>		LOCATION (City, town, or county) (State) <u>Md</u>	
24. REC'D BY REGISTRAR <u>3/24/55</u>		REGISTRAR'S SIGNATURE <u>Louise M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Ruggold</u>		ADDRESS <u>1463 N. Carey</u>	

1

INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2279

CERTIFICATE OF DEATH

02247

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>11 mos. 29 days</u>		TOWN <u>Baltimore City</u>		<u>3/01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1718 W. Lafayette Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Jeanette</u>		(Middle) <u>S.</u>		(Last) <u>Green</u>		(Month) <u>3</u> (Day) <u>2</u> (Year) <u>19 55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>12/5/74</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> - - - </u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Thomas J. Hilliard</u>				14. MOTHER'S MAIDEN NAME <u>Harriet N. Hilliard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>450.0</u>				Generalized Arteriosclerosis			
ANTECEDENT CAUSE(S) DUE TO				Known to us since <u>3/4/54</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u> - - </u>		19b. MAJOR FINDINGS OF OPERATION <u> - - - </u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> - - - </u>		21c. WHERE DID INJURY OCCUR? (City or town) <u> - - - </u> (County) <u> - - </u> (State) <u> - </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> - - - </u> M. <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u> - - - </u>			
22. I hereby certify that I attended the deceased from <u>3/4</u> , 19 <u>54</u> , to <u>3/2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/2</u> , 19 <u>55</u> , and that death occurred at <u>4 a.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> (Dr. Benedict)				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>3/2/55</u>			
23. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u> - - </u>		DATE THEREOF <u>3/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		LOCATION (City, town, or county) (State) <u>Baltimore City, Maryland</u>	
24. REC'D BY REGISTRAR <u>Mar. 8, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u> ADDRESS <u>1808 N. Monroe St. Balto. 17. Md.</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

REG. NO. 100

1. DEATH RECORDING BOARD OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. TIME OF DEATH

11. PLACE OF DEATH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERK

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF NATION

23. SIGNATURE OF WORLD

24. SIGNATURE OF UNIVERSE

25. SIGNATURE OF GOD

26. SIGNATURE OF HEAVEN

27. SIGNATURE OF EARTH

28. SIGNATURE OF FIRE

29. SIGNATURE OF WATER

30. SIGNATURE OF AIR

31. SIGNATURE OF LIGHT

32. SIGNATURE OF DARKNESS

33. SIGNATURE OF LIFE

34. SIGNATURE OF DEATH

35. SIGNATURE OF HOPE

36. SIGNATURE OF DESPAIR

37. SIGNATURE OF LOVE

38. SIGNATURE OF HATE

39. SIGNATURE OF KINDNESS

40. SIGNATURE OF CRUELTY

41. SIGNATURE OF GENTLENESS

42. SIGNATURE OF RAGE

43. SIGNATURE OF MEekNESS

44. SIGNATURE OF PRIDE

45. SIGNATURE OF HUMILITY

46. SIGNATURE OF ENVY

47. SIGNATURE OF JEALOUSY

48. SIGNATURE OF CHARITY

49. SIGNATURE OF GREED

50. SIGNATURE OF SLAVENRY

51. SIGNATURE OF FREEDOM

52. SIGNATURE OF OPPRESSION

53. SIGNATURE OF TRUTH

54. SIGNATURE OF LIES

55. SIGNATURE OF JUSTICE

56. SIGNATURE OF INJUSTICE

57. SIGNATURE OF MERCY

58. SIGNATURE OF CLEMENCY

59. SIGNATURE OF RIGOR

60. SIGNATURE OF LENIENCY

61. SIGNATURE OF SEVERITY

62. SIGNATURE OF GENTLENESS

63. SIGNATURE OF MODERATION

64. SIGNATURE OF EXCESS

65. SIGNATURE OF TEMPERANCE

66. SIGNATURE OF DRUNKENNESS

67. SIGNATURE OF SOBRIETY

68. SIGNATURE OF PURITY

69. SIGNATURE OF IMPURITY

70. SIGNATURE OF VIRTUE

71. SIGNATURE OF VICE

72. SIGNATURE OF GOODNESS

73. SIGNATURE OF EVILNESS

74. SIGNATURE OF BEAUTY

75. SIGNATURE OF UGLINESS

76. SIGNATURE OF STRENGTH

77. SIGNATURE OF WEAKNESS

78. SIGNATURE OF RICHES

79. SIGNATURE OF POVERTY

80. SIGNATURE OF HONOR

81. SIGNATURE OF DISHONOR

82. SIGNATURE OF GLORY

83. SIGNATURE OF SHAME

84. SIGNATURE OF PAIN

85. SIGNATURE OF JOY

86. SIGNATURE OF SORROW

BUREAU V. 1

MAR 8 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2280 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

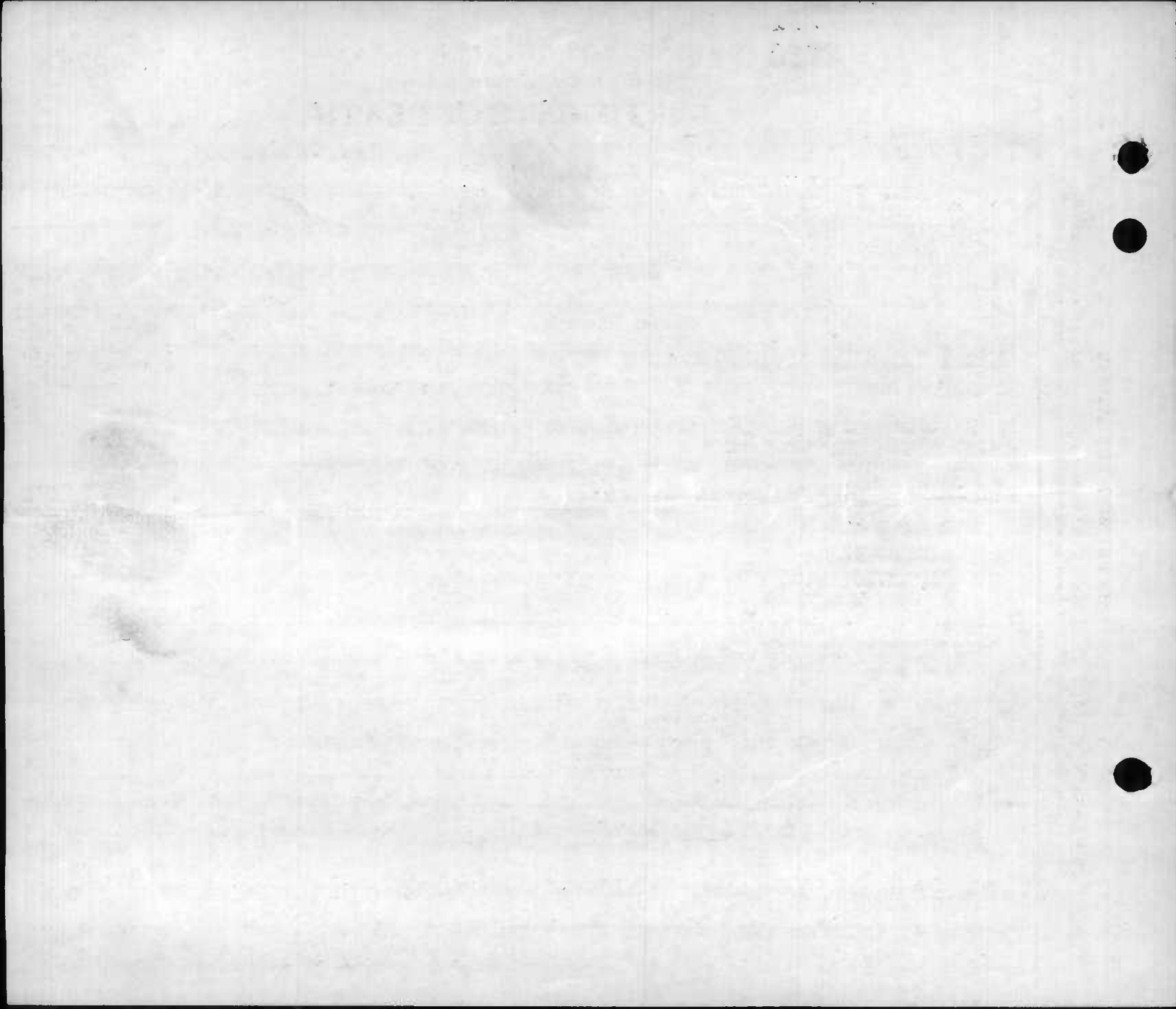
02248

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 8, Film G179 4-1-55 et

1. PLACE OF DEATH - COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hamover</u> TOWN				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hamover Rural</u> TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Elbridge Landing Rd</u>				STREET ADDRESS (If rural, give location) <u>Elbridge Landing Rd</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Rachel</u> (Middle) <u>Mariah</u> (Last) <u>Greene</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>July 15, 1885</u> 9. AGE last birthday <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co</u>	
13. FATHER'S NAME <u>Nicholas Greene</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>andover, MD</u> <u>Elgenea Shands, Lenthicum Heights, Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4221 Immediate cause (a) <u>Chor Myocarditis</u>						6 mo	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>General arterio</u>						3 yrs	
(c) <u>Sclerosis</u>						3 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 20, 1955</u> , to <u>March 22, 1955</u> , that I last saw the deceased alive on <u>March 21, 1955</u> , and that death occurred at <u>2 22</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>Dr B B Brumbaugh</u>				(Degree or title)		ADDRESS <u>27 W 3/22/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/25/1955</u>		<u>St. Rest Cem</u>		<u>Harmons Md</u>	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/25/55</u>		<u>A.W. Hedrick</u>		<u>Mrs Kate Williams</u>		<u>Schreder St</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2242

02249

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 18 Film G179 3/18/55 ans
 Item 9, Film G178 3-15-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>AA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>		LENGTH OF STAY (in this place) <u>2 days</u>		TOWN <u>Annapolis, Md.</u>		TOWN <u>Annapolis, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital, Annapolis</u>				STREET ADDRESS (If rural give location) <u>29 Badger Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>William</u> (Middle) <u>Arthur</u> (Last) <u>GREGORY</u>				OF DEATH <u>March</u> <u>6</u> 19 <u>55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>9-11-28</u>	9. AGE last birthday <u>27</u> / <u>26</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USN</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Arthur Gregory Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Agness Jeffers Stackhouse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>U.S.N.H Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
193x IMMEDIATE CAUSE (A) <u>Tumor, Brain (#193) Ependymoma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Ind.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-7</u> , 19 <u>55</u> , to <u>3-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-7</u> , 19 <u>55</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R.H. Brown</u>				DATE SIGNED <u>3-6-55</u>			
R.H. BROWN LCDR MC USN				M.D. <u>USNH, Annapolis, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>3-7-55</u>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B.L. Hopping and Son</u>		ADDRESS <u>Annapolis, Md.</u>	
DATE <u>3-7-1955</u>							

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE, MD.

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

7

9-1-5

6

Signature of Physician

Signature of Registrar

Signature of Physician

Y-2

Now, with 193

BUREAU V. S.

MAR 10 1955

RECEIVED

DATE

3-7-55

Signature of Registrar

Signature of Registrar

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
2243
CERTIFICATE OF DEATH

02250

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 A. A. GENERAL Hospt</u>				STREET ADDRESS <u>138 CHARLES</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>ELLEN KEY HABERSHAM</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 - 10 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>SINGLE</u>	8. DATE OF BIRTH <u>NOV. 23-1870</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME <u>ALEXANDER WYLLY HABERSHAM</u>				14. MOTHER'S MAIDEN NAME <u>JESSIE STEELE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>MRS FOSTER HANNAFORD (2)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
162x IMMEDIATE CAUSE (A) <u>TRACHEAL OBSTRUCTION</u>						<u>SECONDS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>MALIGNANCY OF TRACHEA</u>						<u>SEVERAL MONTHS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARCINOMA OF TRACHEA</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>REHABILITATION</u>							
19a. DATE OF OPERATION <u>10 MARCH 55</u>		19b. MAJOR FINDINGS OF OPERATION <u>TUMOR OF TRACHEA (CARCINOMA)</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 MARCH 1955</u> , to <u>10 MARCH 55</u> , that I last saw the deceased alive on <u>10 MARCH 55</u> , and that death occurred at <u>11:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. B. Reddy</u>				M.D. <u>59 Franklin</u>		ADDRESS (Street, city, town, state) <u>Annopolis Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Annes Cemt</u>		LOCATION (City, town, or county) (State) <u>Annopolis Md</u>	
24. REC'D BY REGISTRAR <u>March 14, 1955</u>		REGISTRAR'S SIGNATURE <u>J. B. Reddy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M Taylor Sons</u>		ADDRESS <u>Annopolis Md</u>	

02520

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. DATE OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERK	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF TOWNSHIP CLERK	
22. SIGNATURE OF VOTING CLERK		23. SIGNATURE OF SCHOOL CLERK		24. SIGNATURE OF CHURCH CLERK	
25. SIGNATURE OF POST OFFICE CLERK		26. SIGNATURE OF RAILROAD CLERK		27. SIGNATURE OF AIRLINE CLERK	
28. SIGNATURE OF MARINE CLERK		29. SIGNATURE OF NAVY CLERK		30. SIGNATURE OF ARMY CLERK	
31. SIGNATURE OF AIR FORCE CLERK		32. SIGNATURE OF SPACE CLERK		33. SIGNATURE OF OTHER CLERK	

UNCLASIFIED

BUREAU V. S.

MAR 15 1955

RECEIVED

2281

02251

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Same</u>		COUNTY <u>Same</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
<u>X</u> TOWN <u>Severn</u>		<u>All life</u>		TOWN <u>Same</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Queenstown Road</u>				STREET ADDRESS (If rural give location) <u>Same</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)				
<u>Edward</u> <u>Hall</u>			<u>March 15</u> <u>19 55</u>				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M.</u>	<u>Colored</u>	<u>Widowed ?</u>		<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Retired labor.</u>					<u>Severn, Md.</u>		<u>U.S.A.</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Jerry Hall</u>				<u>Lille Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>4</u> <u>No</u>		<u>No</u>		<u>Asahall Hall (son)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
443X Immediate cause (a) <u>Hypertensive cardio vascular diseases</u>						<u>?</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Acute prostatitis</u>						<u>?</u>	
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from <u>3/2/55</u> , 19....., to <u>3/15/55</u> , 19....., that I last saw the deceased alive on <u>3/10/55</u> 19....., and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Glenn Burnie</u> (Degree or title)				DATE SIGNED <u>3/15/55</u>			
ADDRESS <u>Glen Burnie Md.</u>							
23. BURIAL, CREMATION, REPOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/15/1955</u>		<u>St. Catharine</u>		<u>Brooklyn - Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>3-15-55</u>		<u>Harold</u>		<u>Marshall P. Hays 638 N. Helmer</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2244

CERTIFICATE OF DEATH

02252

21

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		50 Yrs.		TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 76 Franklin Street				76 Franklin Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
CARRIE OLIVIA HARDESTY				3/14/1955 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Colored	Married	March 6, 1893	62 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		None		Galesville A.A. Co. Maryland		-----	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James Turner				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Annapolis, Maryland Walter Hardesty-76 Franklin Street			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						1 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work or Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Jan 12, 1955, to March 14, 1955, that I last saw the deceased alive on 3/14, 1955, and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
Ethel L. Hicks		110 - Clay Street Annapolis		3/14/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		March 15, 1955		Brewer Hill Cemetery		West St. Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE March 15, 1955		Ethel L. Hicks		Ethel L. Hicks -45 Northwest St. Annapolis		Maryland	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
2245

CERTIFICATE OF DEATH

02253

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		<u>1 day</u>		TOWN <u>Galesville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>OSCAR Emile Hartge</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 30 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 3 1875</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARINE</u>		11. BIRTHPLACE (State or foreign country) <u>Shadyside MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Emile Alexander Hartge</u>				14. MOTHER'S MAIDEN NAME <u>Susan V. Edgar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>388 20 5087</u>		17. INFORMANT & ADDRESS <u>Susan V. Edgar, Galesville MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
260X IMMEDIATE CAUSE (A) <u>Diabetic Coma</u>						<u>12 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction?</u>						<u>12 hr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY—street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/29</u> , 19 <u>55</u> , to <u>3/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>55</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Schiefly</u>				ADDRESS (Street, city, town, state) <u>Annapolis</u>		DATE SIGNED <u>3/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>Luther</u>		LOCATION (City, town, or county) (State) <u>Galesville Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>U. S. S. S. S.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Galesville Md</u>	
DATE <u>April 1, 1955</u>							

SMOOTH JOURNAL

RECEIVED
APR 6 1955
BUREAU V. S.

CERTIFICATE OF DEATH

MANLYND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

8245

Reg. Dist. No.

NAME OF DECEASED

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

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TIME OF DEATH

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2246

02254

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 A.A. GENERAL</u>				STREET ADDRESS (If rural give location) <u>DEFENCE HIGHWAY</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>C. ADDISON HODGES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3-28 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY <u>MARRIED</u>		8. DATE OF BIRTH <u>4-3-1885</u>	
9. AGE last birthday <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROBATION OFFICER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AA Co.</u>		11. BIRTHPLACE (State or foreign country) <u>AA Co. MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN THOMAS HODGES</u>		14. MOTHER'S MAIDEN NAME <u>IDA KENT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>JOHN HODGES DAVIDSONVILLE MD</u>		18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
540.1 IMMEDIATE CAUSE (A) <u>peritonitis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rupture + necrosis transverse colon</u>				<u>18 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>gastric ulcer</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>March 15, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>gastric ulcer, 2 necrosis transverse colon</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-13</u>, 19<u>54</u>, to <u>3-28</u>, 19<u>55</u>, that I last saw the deceased alive on <u>3-27</u>, 19<u>55</u>, and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Edith Pooler</u>				DATE SIGNED <u>M.D. 45 Franklin St. Annapolis Md 3-28-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar 29 1955</u>		NAME OF CEMETERY OR CREMATORY <u>All Hallors Chapel</u>		LOCATION (City, town, or county) (State) <u>Davidsonville Md</u>	
24. REC'D BY REGISTRAR <u>March 29, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Drunch</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	

CERTIFICATE OF DEATH

For State Use

LOCAL HEALTH DEPARTMENT OF BALTIMORE

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

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PLACE OF REINTERMENT

RECEIVED

BUREAU V. S.

MAR 31 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2282

CERTIFICATE OF DEATH

02255

Item 9, Film G178 3-16-55 et

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) Gambrills		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Gambrills			
HOSPITAL OR INSTITUTION OR STREET ADDRESS "Rose Hill"				STREET ADDRESS "Rose Hill"			
3. NAME OF DECEASED (First) (Middle) (Last) MATILDA DARE HOPKINS				4. DATE OF DEATH (Month) (Day) (Year) March 1, 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH April 30, 1880	9. AGE last birthday 74 7/8 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Gambrills, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Snowden Hopkins				14. MOTHER'S MAIDEN NAME Matilda Elizabeth Matilda			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) none		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mr. C. Edward Hopkins, same as # 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170x IMMEDIATE CAUSE (A) Adenocarcinoma - Rt Breast				INTERVAL BETWEEN ONSET AND DEATH 6 MO			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 1946, to Mar 1, 1955, that I last saw the deceased alive on Mar 1, 1955, and that death occurred at 9:40 P.M. from the causes and on the date stated above.							
SIGNATURE Edward G. Bennett M.D.				ADDRESS (Street, city, town, state) Gambrills		DATE SIGNED 3-2-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 3, 55		NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		LOCATION (City, town, or county) (State) Millersville, Maryland	
24. REC'D BY REGISTRAR DATE 3-4-55		REGISTRAR'S SIGNATURE K. M. Lee		25. FUNERAL DIRECTOR'S SIGNATURE Ben J. Hopping and Son			

CERTIFICATE OF DEATH

Name (Print) Anne Arnold		Date of Birth 1900		Sex Female		Race White		Marital Status Single		Date of Death 1955	
Address 1234 Main St Baltimore, Md		Cause of Death Heart Disease		Place of Death Home		Date of Death 1955		Time of Death 10:00 AM		Signature of Doctor J. D. Smith	
Signature of Informant J. D. Smith		Signature of Informant J. D. Smith		Signature of Informant J. D. Smith		Signature of Informant J. D. Smith		Signature of Informant J. D. Smith		Signature of Informant J. D. Smith	

RECEIVED
 MAR 10 1955
 BUREAU OF HEALTH - BALTIMORE, MD

2283
CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>ANNE ARUNDEL</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>ANNE ARUNDEL</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROUTE #3 - ANNAPOLIS</u>	LENGTH OF STAY (in this place) <u>2 WKS.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROUTE #3 - ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WILD ROSE SHORES</u>		STREET ADDRESS (If rural give location) <u>WILD ROSE SHORES</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>ADA</u>	(Middle) <u>LOUISE</u>	(Last) <u>HOYE</u>	(Month) <u>MARCH</u> (Day) <u>8</u> (Year) <u>1955</u>
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>FEB 7 / 1871</u>
9. AGE last birthday: <u>84</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>FLAT ROCK, MICH.</u>	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>GEORGE MILTON READING</u>		14. MOTHER'S MAIDEN NAME: <u>FLORENCE MIGHLES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>GEORGE G. HOYE - ROUTE #3 - ANNAPOLIS, MD.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>151X Possible Gastric Carcinoma</u>		<u>unknown</u>
(b) Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <u>DUE TO</u>		
(c) <u>DUE TO</u>		

11. OTHER SIGNIFICANT CONDITIONS		12. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		22. PLACE (Home, farm, factory, street, office bldg., etc.) <u>OFFICE BLDG.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED <u>White at Work</u> <input type="checkbox"/> <u>Not While At Work</u> <input type="checkbox"/>	
HOW DID INJURY OCCUR ?			

22. I hereby certify that I attended the deceased from <u>3-8</u> , 1955, to <u>3-8</u> , 1955, that I last saw the deceased alive on <u>3-8</u> , 1955, and that death occurred at <u>2:45 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>E. Edward Beck MD</u>		DATE SIGNED <u>3-8-55</u>	
23. BURIAL, CREMATION, REBURY (Specify) <u>BURIAL</u>		DATE THEREOF <u>3/11/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smithland Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 9, 1955</u>		REGISTRAR'S SIGNATURE <u>James Sever</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co - RIVERDALE, MD.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 14 1935

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2247

CERTIFICATE OF DEATH

02257

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA Co.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>ANNA POLIS</u>				10 TOWN <u>ANNA POLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>35 BUNCHE ST</u>				STREET ADDRESS (If rural give location) <u>35 BUNCHE ST</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELIA</u> (Middle) <u>JACKSON</u> (Last)				(Month) <u>3</u> (Day) <u>8</u> (Year) <u>1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>7-29-1885</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Moulden</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>George Trehand 35 Bunche St</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>442x Arteriosclerotic Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chorea</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 18, 1954</u> , to <u>March 8, 1955</u> , that I last saw the deceased alive on <u>March 8, 1955</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert L. Brown</u> M.D. <u>Anna Polaris</u>				DATE SIGNED <u>3/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brown Hill</u>		LOCATION (City, town, or county) <u>ANNA POLIS Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. W. Adams</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Ross</u>		ADDRESS <u>128 Washington</u>	
DATE <u>3-10-55</u>						<u>ANNA POLIS MD</u>	

BUREAU W. S.

114

RECEIVED
MAR 7

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2284

CERTIFICATE OF DEATH

02258

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AnneArundel</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Crownsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>58 Douglas Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Philip</u> (First) <u>Jenkins</u> (Middle) (Last)				4. DATE OF DEATH 3 16 1955 (Month) (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1880?</u>	9. AGE last birthday <u>75?</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						Known to us since <u>12/30/54</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>00</u>			
21d. TIME OF INJURY (Month) (Day) (Year) M. et work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/30</u> , 19 <u>54</u> , to <u>3/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/16</u> , 19 <u>55</u> , and that death occurred at <u>1:50a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict, M. D.</u>		M. D.		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>3/18/55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Stolar</u> ADDRESS <u>317 High Street Cambridge Md</u>			

STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

43258

RECEIVED

MAR. 18 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2285

02259

CERTIFICATE OF DEATH

Reg. Dist. No. 2A

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A A</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>x</u> TOWN <u>Fralesville</u>		<u>14 yrs</u>		TOWN <u>Fralesville</u> <u>MD</u>		<u>x</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Agnes</u> (Middle) <u>Johnson</u> (Last)				(Month) <u>MAR</u> (Day) <u>19</u> (Year) <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>C</u>	<u>widow</u>	<u>Aug 25</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Birdsville MD</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ben Duwall SR.</u>				<u>Isabell Simms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>4 NO</u>		<u>None</u>					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A) <u>Carcinoma of Stomach</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY?			
<u>0</u>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-19-55</u> , 19 <u>55</u> , to <u>3-19-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-18-55</u> , 19 <u>55</u> , and that death occurred at <u>4:45 P</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Chris T. Ryan</u> M.D.				ADDRESS (Street, city, town, state) <u>10 Carroll St</u>		DATE SIGNED <u>3-2-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/23/55</u>		<u>Lady of Sorrows</u>		<u>Owensville MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>March 23, 1955</u>		<u>Mr. Edward Collier</u>		<u>Bernard Hardisty</u>		<u>Fralesville, Md</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2286

02260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY OR TOWN <u>Crownsville</u> LENGTH OF STAY (in this place) <u>20 months</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>723 W. Fayette St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Hattie Jones</u>				4. DATE OF DEATH <u>March 24 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Unk.</u>	9. AGE last birthday <u>67?</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Unk.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>			16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebrovascular Accident</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive & Arteriosclerotic Cardiovascular D's.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>6/11</u> , 1953, to <u>3/24</u> , 1955, that I last saw the deceased alive on <u>3/24</u> , 1955, and that death occurred at <u>8:45</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>Stanley C. Bergeron</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THROEF <u>3/30/55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem.</u>		LOCATION (City, town, or county) <u>Balto. Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>3/28/55</u>	REGISTRAR'S SIGNATURE <u>Richard M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hester</u>		ADDRESS <u>1918 Snow Hill</u>		

1955

WEST AND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

8228

Reg. Dist. No.

1. USUAL RESIDENCE PRIOR TO DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

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BUREAU V. S.

MAR 29 1955

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BALTIMORE, MARYLAND
DEPARTMENT OF HEALTH

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INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2287

02261

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>BELHAVEN BEACH</u>		<u>3 YRS</u>		TOWN <u>Belhaven Beach</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lakewood Road</u>				STREET ADDRESS (If rural give location) <u>Lakewood Road</u>			
3. NAME OF DECEASED (Type or Print) <u>JOHN K. F. KESTING</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>10/26/10</u>		9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR (Months) <u></u> (Days) <u></u> IF UNDER 24 HRS. (Hours) <u></u> (Min.) <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Burners</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick John Kesting</u>				14. MOTHER'S MAIDEN NAME <u>Mahida Benner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-03-1150</u>		17. INFORMANT & ADDRESS <u>Mrs. H. Kesting - wife (same)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
163X IMMEDIATE CAUSE (A) <u>Carcinoma Lung</u>						<u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/14</u> 19 <u>55</u> to <u>3/16</u> 19 <u>55</u> that I last saw the deceased alive on <u>3/15</u> 19 <u>55</u> and that death occurred at <u>8:45 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>J. Brady Smith</u>				ADDRESS (Street, city, town, state) <u>Riviera Beach, Md.</u>		DATE SIGNED <u>3/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>		LOCATION (City, town, or county) (State) <u>DORSEY WASHINGTON BLVD. HOWARD CO. MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. D'Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. SINGLETON</u>		ADDRESS <u>GREEN BURNIE, MD</u>	
DATE <u>March 17, 1955</u>							

1955

BALTIMORE STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

2287

Form 2287-10-54

1. PLACE OF BIRTH

MARYLAND

COUNTY

STATE

CITY

TOWN

ZIP CODE

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BUREAU V. S.

MAR 21 1955

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PHOTOGRAPH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2248

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02262

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md</u> COUNTY <u>A.A. Co.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>10 ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>ANNAPOLIS Md. 10</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 ANNE ARUNDEL GENERAL</u>				STREET ADDRESS <u>40 Southgate Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>MARGARET Dowling King</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 27 19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept 11, 1875</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS DOWLING</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE CHRISTOPHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>WM F. KING ANNAPOLIS MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153X IMMEDIATE CAUSE (A) <u>Cancer of Bowel with</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 mos.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastases to liver.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/27/55</u> , to <u>3/27/55</u> , that I last saw the deceased alive on <u>3/27/55</u> , 19 <u>55</u> , and that death occurred at <u>10:30 A</u> M, from the causes and on the date stated above. SIGNATURE <u>Frank M. Shilly</u> M.D. <u>annapolis</u> DATE SIGNED <u>3/29/55</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>BAKOWIN MEMORIAL</u>		LOCATION (City, town, or county) (State) <u>MILLERSVILLE MD.</u>	
24. REC'D BY REGISTRAR <u>March 29, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor + Sons</u>		ADDRESS <u>ANNAPOLIS MD.</u>	

CERTIFICATE OF DEATH

Form 100-10

1. NAME OF DECEASED (Print or Type)

2. SEX (Male or Female)

3. DATE OF BIRTH (Month, Day, Year)

4. PLACE OF BIRTH (City, State, Country)

5. OCCUPATION (Print or Type)

6. CAUSE OF DEATH (Print or Type)

7. PLACE OF DEATH (Print or Type)

8. TIME OF DEATH (Print or Type)

9. SIGNATURE OF PHYSICIAN (Print or Type)

10. SIGNATURE OF REGISTRAR (Print or Type)

11. DATE OF DEATH (Print or Type)

12. PLACE OF DEATH (Print or Type)

13. TIME OF DEATH (Print or Type)

14. SIGNATURE OF PHYSICIAN (Print or Type)

15. SIGNATURE OF REGISTRAR (Print or Type)

16. DATE OF DEATH (Print or Type)

17. PLACE OF DEATH (Print or Type)

18. TIME OF DEATH (Print or Type)

19. SIGNATURE OF PHYSICIAN (Print or Type)

20. SIGNATURE OF REGISTRAR (Print or Type)

21. DATE OF DEATH (Print or Type)

22. PLACE OF DEATH (Print or Type)

23. TIME OF DEATH (Print or Type)

24. SIGNATURE OF PHYSICIAN (Print or Type)

25. SIGNATURE OF REGISTRAR (Print or Type)

26. DATE OF DEATH (Print or Type)

27. PLACE OF DEATH (Print or Type)

28. TIME OF DEATH (Print or Type)

29. SIGNATURE OF PHYSICIAN (Print or Type)

30. SIGNATURE OF REGISTRAR (Print or Type)

31. DATE OF DEATH (Print or Type)

32. PLACE OF DEATH (Print or Type)

33. TIME OF DEATH (Print or Type)

34. SIGNATURE OF PHYSICIAN (Print or Type)

35. SIGNATURE OF REGISTRAR (Print or Type)

36. DATE OF DEATH (Print or Type)

37. PLACE OF DEATH (Print or Type)

38. TIME OF DEATH (Print or Type)

39. SIGNATURE OF PHYSICIAN (Print or Type)

40. SIGNATURE OF REGISTRAR (Print or Type)

41. DATE OF DEATH (Print or Type)

42. PLACE OF DEATH (Print or Type)

43. TIME OF DEATH (Print or Type)

44. SIGNATURE OF PHYSICIAN (Print or Type)

45. SIGNATURE OF REGISTRAR (Print or Type)

46. DATE OF DEATH (Print or Type)

47. PLACE OF DEATH (Print or Type)

48. TIME OF DEATH (Print or Type)

49. SIGNATURE OF PHYSICIAN (Print or Type)

50. SIGNATURE OF REGISTRAR (Print or Type)

BUREAU V. S.

MAR 31 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2249

CERTIFICATE OF DEATH

02263

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EMERGENCY HOSP.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>3322 CHARKS HANE</u>			
3. NAME OF DECEASED (Type or Print) <u>JULIUS A. KRAWANS</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>3-18-1955</u> (Month) (Day) (Year)			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>MARRIED</u>	8. DATE OF BIRTH <u>8-9-1896</u>	9. AGE last birthday <u>58</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if deceased) <u>MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MENS WEAR</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>	
13. FATHER'S NAME <u>DAVID</u>				14. MOTHER'S MAIDEN NAME <u>LENA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MOHAYE KRAWANS - SAME</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Myocardial Infarction, anterior</u>						<u>5 day</u>	
ANTECEDENT CAUSE(S) <u>DOE TO</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Septal</u> <u>1200 X</u> (C) <u>Congestive Failure</u>						<u>1 day.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/14</u> , 19 <u>55</u> , to <u>3/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>55</u> , and that death occurred at <u>10 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>		ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>3/18/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. REC'D BY REGISTRAR <u>March 22, 1955</u>		REGISTRAR'S SIGNATURE <u>Thm. J. Zurech</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u>		ADDRESS <u>2100 Eutan Pl</u>	

2219 CERTIFICATE OF DEATH

FILE NO.

DEATH NUMBER

MARYLAND

DEATH OF

THOMAS A. KIRWAN

THOMAS A. KIRWAN

THOMAS A. KIRWAN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

BY MEDICAL CERTIFICATION

BY MEDICAL CERTIFICATION

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BUREAU V. S.

MAR 22 1955

REGISTERED

ENCLOSURE

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INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02264

2288

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>GLEN BURNIE</u>		LENGTH OF STAY (in this place) <u>11 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 THIRD AVE., S.W.</u>				STREET ADDRESS (If rural give location) <u>201 THIRD AVE., S.W.</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Martha</u> <u>-</u> <u>Kriewald</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>3</u> <u>19 55</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>OCT. 19, 1885</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK DEKORABER</u>				14. MOTHER'S MAIDEN NAME <u>BERTHA LUDTKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS. ALMA TRIUMPIER</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4201 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis & Hypertension</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 27</u> , 19 <u>34</u> , to <u>March</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-26</u> , 19 <u>55</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>McDonald</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie MD</u>		DATE SIGNED <u>3-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>DEICHGRABER PRIVATE</u>		LOCATION (City, town, or county) (State) <u>QUARTERFIELD ROAD SEVERN MD</u>	
24. REC'D BY REGISTRAR DATE <u>March 5, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. Dealba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Hamilton</u>		ADDRESS <u>Glen Burnie, MD</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2250 MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

02265

Reg. Dist. No. 142

1. PLACE OF DEATH - COUNTY <u>HA. CO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD.</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MD.</u>	
TOWN <u>Annapolis</u>		TOWN <u>BETHESDA, MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>BRADLEY BLVD RIVER RD.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Albert</u>	(Middle) <u>EDWARD</u>	(Last) <u>LANDVOIGT</u>
4. DATE OF DEATH	(Month) <u>3</u>	(Day) <u>26</u>	(Year) <u>1955</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>JAN 11, 1892</u>
9. AGE last birthday <u>63</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>D. C.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>EDWARD LANDVOIGT</u>		14. MOTHER'S MAIDEN NAME <u>VERGIA ANN WHEGLOCK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WLOI</u>	
17. INFORMANT			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH Sudden

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mar. 28, 55Carrie J. CampbellWm. J. French300 4th St. N.E. WASH. D.C.

BUREAU V. S.

APR 1 1955

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CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>P.O. Pasadena</i> LENGTH OF STAY (In this place) <i>30 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Anne Arundel</i> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Green Gables</i>		STREET ADDRESS (If rural, give location) <i>1</i>	
3. NAME OF DECEASED (First) (Middle) (Last) <i>Samuel Joseph Lemieux</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>March 9 1955</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>9/12/93</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Repairing light bulbs</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>61</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Maine, U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Yes 1907</i>		16. SOCIAL SECURITY NO. <i>212-26-0841</i>	
17. INFORMANT AND ADDRESS <i>Remains found in his home.</i>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1 Immediate cause (a) Coronary Occlusion</i> Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>m.</i>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <i>Eustace H. Parker M.D.</i>		ADDRESS <i>Off. of Medical Examiner, Glen Burnie</i> DATE SIGNED <i>3/9/55</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>		DATE THEREOF <i>MARCH 11, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>BALTIMORE NATIONAL</i>		LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i>	
DATE REC'D BY LOCAL REG. <i>3-10-55</i>		REGISTRAR'S SIGNATURE <i>A.W. Hedrick</i>	
24. FUNERAL DIRECTOR <i>Wm. Cook-Blythe</i>		ADDRESS <i>6009 HARFORD Rd.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2251

-CERTIFICATE OF DEATH

02267

Reg. Dist. No. 21

Item 7. Film 179 3-23-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>AA.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <i>Annapolis</i>		4 mos.		10 TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Homewood Convalescing Home</i>				STREET ADDRESS (If rural give location) <i>1312 West St. Annapolis Md.</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>JAMES</i> (Middle) <i>E</i> (Last) <i>LEWIS</i>				(Month) <i>March</i> (Day) <i>6</i> (Year) <i>1955</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Jan. 8, 1875</i>	9. AGE last birthday <i>80</i> yrs.	IF UNDER 1 YEAR Months <i>1</i> Days <i>25</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Care Taker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>London Park Century</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Alfred Lewis</i>				14. MOTHER'S MAIDEN NAME <i>Annabelle Wenter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-07-7266</i>		17. INFORMANT & ADDRESS <i>Mildred L. Conley 2237 W. Balto. St.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <i>Arteriosclerotic Cardio Vascular</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>drenal with decompensation</i>						<i>Yes.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/4</i> 1955, to <i>3/6</i> 1955, that I last saw the deceased alive on <i>3/4</i> 1955, and that death occurred at <i>9 P.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Mamie K. Korman</i>				ADDRESS (Street, city, town, state) <i>Annapolis, Md.</i>			
DATE <i>3/14/55</i>				DATE SIGNED <i>3/18/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-10-55</i>		NAME OF CEMETERY OR CREMATORY <i>Kemptown</i>		LOCATION (City, town, or county) (State) <i>Frederick Co. Md.</i>	
24. REC'D BY REGISTRAR <i>3/14/55</i>		REGISTRAR'S SIGNATURE <i>Thos. J. Funch</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Cole</i>		ADDRESS <i>1913 W. Balto. St.</i>	

CERTIFICATE OF DEATH

Form No. 10-1

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. MANNER OF DEATH (Print or Write)

9. PLACE OF DEATH (Print or Write)

10. TIME OF DEATH (Print or Write)

11. SIGNATURE OF PHYSICIAN (Print or Write)

12. SIGNATURE OF REGISTRAR (Print or Write)

13. SIGNATURE OF WITNESS (Print or Write)

14. SIGNATURE OF DECEASED (Print or Write)

15. SIGNATURE OF NEXT OF KIN (Print or Write)

16. SIGNATURE OF CLERK (Print or Write)

17. SIGNATURE OF CHURCH CLERK (Print or Write)

18. SIGNATURE OF MINISTERS (Print or Write)

19. SIGNATURE OF BURIAL SOCIETY (Print or Write)

20. SIGNATURE OF OTHER (Print or Write)

BUREAU V. S.

MAR 16 1955

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MARYLAND

2290

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Anne Arundel</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Earleigh Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Earleigh Heights</u>	
OR TOWN <u>Earleigh Heights</u>		OR TOWN <u>Earleigh Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 449 Severna Park Md.</u>		STREET ADDRESS (If rural, give location) <u>Box 449 Severna Park Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>Elsie Marie Listman</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 1-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>56</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frederick Bunk</u>		14. MOTHER'S MAIDEN NAME <u>ELSA Fricke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>George Listman (Son)</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4201 Immediate cause (a) <u>MYOCARDIAL INFARCTION (Massive)</u>			
Antecedent cause(s) (b) <u>Hypertensive arteriosclerotic Cardio-Vascular disease</u>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>Years</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>have never attended the deceased</u> , 19 <u>10</u> , to <u>10</u> , 19 <u>10</u> , that I last saw the deceased alive on <u>10</u> , 19 <u>10</u> , and that death occurred at <u>10</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Robert R. Halin M.D.</u>		ADDRESS <u>Severna Park Md</u> DATE SIGNED <u>12 March</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>March 16/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran Church</u>		LOCATION (City, town, or county) <u>Howard Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>March 14, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. De Alba</u>	
24. FUNERAL DIRECTOR <u>R. L. Singleton</u>		ADDRESS <u>Elan Bunnie, Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 17 1955
BUREAU V. S.

1954
4561
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6

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2291

CERTIFICATE OF DEATH

02269

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>3 mos. 19 days</u>		TOWN <u>Baltimore City</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>2801 Raynor Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>H.</u> (Last) <u>Lowery</u>				(Month) <u>3</u> (Day) <u>1</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Married</u>	<u>1877?</u>	<u>78?</u> yrs.	Months <u>-</u> Days <u>-</u>	Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>			<u>- - - -</u>	<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>450.0</u> IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>				Known to us since <u>11/10/54</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0 - - - - -</u>		<u>- - - - -</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>- - - - -</u>		<u>- - - - -</u>		<u>- - - - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>- - - - -</u>		<u>M. <input type="checkbox"/></u>		<u>- - - - -</u>			
22. I hereby certify that I attended the deceased from <u>11/10</u>, 19 <u>54</u>, to <u>3/1</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>3/1</u>, 19 <u>55</u>, and that death occurred at <u>3:45 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/1/55</u>	
23. BURIAL, CREMATION, REINTERMENT (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/5/55</u>		<u>Mt. Auburn</u>		<u>Baltimore City</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Mar. 7, 1955</u>		<u>Katherine M. Joyce</u>		<u>Mrs. Katie R. Williams</u>		<u>322 N. Schroeder St.</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 7 1965

RECEIVED

2252

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis Md.</u>		STATE <u>Md.</u> COUNTY <u>aa</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. General</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		132 Charles	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>James Mitchell Magruder</u>				OF DEATH: <u>3-11-1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>8-4-1865</u>	9. AGE last birthday: <u>89</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or retired): <u>Minister</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Episcopal</u>		11. BIRTHPLACE (State or foreign country): <u>Mississippi</u>	
13. FATHER'S NAME: <u>William Howard Magruder</u>				12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Margaret M. Magruder</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
452X IMMEDIATE CAUSE (A) <u>Gangrene (dry) right foot</u>						<u>4 wks.</u>	
ANTECEDENT CAUSE (B) <u>thrombosis of aneurysm of rt. popliteal artery</u>						<u>4 wks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>arteriosclerosis, generalized</u>						<u>yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/10/1955</u> , to <u>3/11/1955</u> , that I last saw the deceased alive on <u>3/10/1955</u> , and that death occurred at <u>3:57 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shively</u>		ADDRESS <u>Annapolis</u>		DATE SIGNED <u>3/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 11, 1955</u>		REGISTERING SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 14 1955

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2292

CERTIFICATE OF DEATH

02271

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Illinois</u> ^{MD}		COUNTY <u>Kankakee</u> ^{Pr Gen}	
CITY OR TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place) <u>2 months</u>		CITY OR TOWN <u>Buckingham - Laurel</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Army Hospital</u>				STREET ADDRESS (if rural give location) <u>1641-21</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Connie Ann McClintock</u>				<u>March 13 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>13 March 1955</u>	9. AGE last birthday <u>3</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	<u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Edward McClintock</u>				14. MOTHER'S MAIDEN NAME <u>Martha Virginia Pfutzenrueter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Father: 89th AAA, Ft GG Meade, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Prematurity - 20 weeks gestation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs 10 min</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1845 13 Mar 55</u> , to <u>2155 13 Mar 19 55</u> , that I last saw the deceased alive on <u>13 Mar 19 55</u> and that death occurred at <u>2155</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frederick S. Eadie</u>				ADDRESS (Street, city, town, state) <u>Fort George G. Meade, Md.</u> DATE SIGNED <u>13 Mar 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal - permission granted to remove remains to Second Army Med Lab, FGGM, Md.</u>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>ARTHUR J. COMBOSH, CAPT., MSC</u>		REGISTRAR'S SIGNATURE <u>Arthur J. Combosh</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>none</u>		ADDRESS	
DATE <u>14 Mar 55</u>							

2035292180

CERTIFICATE OF DEATH

2892

00521

Form No. 27

WILLIAMSON, GEORGE W. JR.

Residence

Age 11 years

MARRIAGE

Single

Black

White

1111 North Street

Baltimore

Age

11 years

11 March 1955

White

Male

Maryland

None

None

1111 North Street

1111 North Street

None

None

1111 North Street

1111 North Street

1111 North Street

1111 North Street

BUREAU V. S.

MAR 16 1955

RECEIVED

1111 North Street

1111 North Street

1111 North Street

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2293

CERTIFICATE OF DEATH

02272

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>2yrs. 2mos. 24 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. #2, Box 87B</u>			
3. NAME OF DECEASED (Type or Print) <u>Wilbert</u> (First) <u>Monroe</u> (Middle) <u>Murray</u> (Last)				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>7</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/23/01</u>		9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William H. Murray</u>				14. MOTHER'S MAIDEN NAME <u>Clara E. Hubbard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>025X</u> IMMEDIATE CAUSE (A) <u>Terminal bronchopneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Paresis</u>						<u>Known to us since 12/11/52</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION <u>- - - - -</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>- - - - -</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- - - - -</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>- - - - -</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>- - - - -</u>			
22. I hereby certify that I attended the deceased from <u>12/11</u> , 19 <u>52</u> , to <u>3/7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>55</u> , and that death occurred at <u>4:30p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict</u>		M.D. (L. Benedict)		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>-</u>		DATE THEREOF <u>3/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Jonestown Cemetery Jonestown</u>		LOCATION (City, town, or county) (State) <u>Md.</u>	
24. REC'D BY REGISTRAR DATE <u>3-12-55</u>		REGISTRAR'S SIGNATURE <u>1 M Soye</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson & Son - Federalburg Md</u>		ADDRESS <u>-</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

8223

Reg. Ord. No.

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF BIRTH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF BIRTH

11. MARITAL STATUS

12. COLOR

13. EDUCATION

14. DATE OF DEATH

15. SEX

16. AGE

17. OCCUPATION

18. PLACE OF BIRTH

19. SEX

20. AGE

21. OCCUPATION

22. PLACE OF BIRTH

23. SEX

24. AGE

25. OCCUPATION

26. PLACE OF BIRTH

27. SEX

28. AGE

29. OCCUPATION

30. PLACE OF BIRTH

31. SEX

32. AGE

33. OCCUPATION

34. PLACE OF BIRTH

35. SEX

36. AGE

37. OCCUPATION

38. PLACE OF BIRTH

39. SEX

40. AGE

41. OCCUPATION

42. PLACE OF BIRTH

43. SEX

44. AGE

45. OCCUPATION

46. PLACE OF BIRTH

47. SEX

48. AGE

49. OCCUPATION

50. PLACE OF BIRTH

51. SEX

52. AGE

53. OCCUPATION

BUREAU V. S.

MAR 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

02273

2253

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>aa</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>903 Jackson</u>		STREET ADDRESS (If rural, give location) <u>903 Jackson</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Carl</u> (Middle) <u>Wayne</u> (Last) <u>Neumiller</u>		4. DATE OF DEATH (Month) <u>3-</u> (Day) <u>29-</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-17-53</u>
9. AGE last birthday <u>2</u> yrs.		10. If under 1 year Months <u>3</u> Days <u>29</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer L. Neumiller</u>		14. MOTHER'S MAIDEN NAME <u>Ruby L. Sears</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Elmer L. Neumiller</u>		(2)	

18. MEDICAL CERTIFICATION

4. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Apoplexy

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) 3rd degree burns - 100% body surface

Sudden

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u>		(CITY OR TOWN) <u>Annapolis</u> (COUNTY) <u>AAcs</u> (STATE) <u>Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3</u> <u>29</u> <u>55</u> <u>A</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>House fire</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>3-31-55</u>	NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>	LOCATION (City, town, or county) <u>Annapolis</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>March 30, 1955</u>	REGISTRAR'S SIGNATURE <u>J. J. ...</u>	24. FUNERAL DIRECTOR <u>John W. Taylor</u>	ADDRESS <u>Sus Annapolis Md.</u>	

BUREAU V. S.

APR 1 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2294

CERTIFICATE OF DEATH

02274

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Tracy's Landing</i>				TOWN <i>Tracy's Landing</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				<i>Mc. Kendree R 14</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Maggie</i> (Middle) <i>Virginia</i> (Last) <i>Ewens</i>				(Month) <i>Nov.</i> (Day) <i>18</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>female</i>	<i>colored</i>	<i>married</i>	<i>Oct. 25, 1884</i>	<i>76</i> yrs.	Months <i>11</i>	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>House wife</i>				<i>U. S. A.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John Brown</i>				<i>Emily Carroll</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Elizabeth Easton</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <i>coronary artery disease with</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>chronic myocardial failure</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov.</i> , 19 <i>53</i> , to <i>March 18</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>March 18</i> , 19 <i>55</i> , and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<i>Emily H. Wilson</i>				<i>Lothian, Md.</i>			
M.D.				DATE SIGNED			
				<i>3-14-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Mar. 22, 1955</i>		<i>Adams</i>		<i>Lothian, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>3-22-55</i>		<i>Elmer W. Hession</i>		<i>J. B. Johnson</i>		<i>Annapolis Md.</i>	

10 MILLION INVESTIGATION OF THE DEATH OF MARTIN LUTHER KING, JR.

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CERTIFICATE OF DEATH

8398

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1937

Form 100-100

IN MEDICAL HISTORY OF DECEASED

MARYLAND
DEPARTMENT OF HEALTH
BALTIMORE, MD

REGISTERED
DECEASED

DEATH

IN MEDICAL CERTIFICATE ON

BUREAU V. 3

MAR 28 1937

RECEIVED

02275

2295 MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pasadena</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lanham</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 87 - Route 1</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Harry</u> <u>Albert</u> <u>Pattleson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>3</u> <u>1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH
9. AGE last birthday <u>79</u> yrs.		10. UNDER 1 year Months Days	11. UNDER 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry A. Pattleson</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>210-10-7104</u>	
17. INFORMANT AND ADDRESS <u>Mr. L. A. Pattleson (Son)</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>420.1 Coronary Occlusion</u>		<u>Sudden</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>General Arterio Sclerosis</u>	
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Harold A. Patterson</u>		ADDRESS <u>Superior Medical Exam. - Glen Burnie, Md.</u>	
DATE SIGNED <u>3/3/55</u>			
23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-7-55</u>	<u>Bowden Park</u>	<u>Baltimore</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>March 10, 1955</u>	<u>L. J. DeAlba</u>	<u>Howard A. Anderson 4107 Wilkes Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 14 1935

K1500-1-511

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2296

CERTIFICATE OF DEATH

02276

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>ODENTON</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ODENTON</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location)		<u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARION I POORE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 31, 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 7, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Mr. James S. Poore- Son- same as # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>						<u>10 years</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>46</u> , to <u>Mar 31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 29</u> , 19 <u>55</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Bennett</u>				ADDRESS (Street, city, town, state) <u>6200 Millersville Rd</u>		DATE SIGNED <u>3-31-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 4, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Fields</u>		LOCATION (City, town, or county) (State) <u>Millersville, A.A. Maryland</u>	
24. REC'D BY REGISTRAR <u>4-3-55</u>		REGISTRAR'S SIGNATURE <u>K M Joy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>ANNAPOLIS, MD.</u>			

BUREAU V. S.

APR 7 1955

RECEIVED

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 415C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02277

2297

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>ODENTON RURAL</u>		LENGTH OF STAY (in this place) <u>36 YRS</u>		CITY OR TOWN <u>ODENTON (RURAL)</u>		CITY OR TOWN <u>ODENTON (RURAL)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WALGH CHAPEL ROAD</u>				STREET ADDRESS (If rural give location) <u>WALGH CHAPEL ROAD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WILLIAM</u> (Middle) <u>PULLMAN</u> (Last) <u>PULLMAN</u>				(Month) <u>15</u> (Day) <u>15</u> (Year) <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>SEPT. 6 1876</u>	<u>78</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMING</u>		<u>OWN FARM</u>		<u>RUSSIA</u>		<u>RUSSIA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>FREDERICK PULLMAN</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>NO</u>		<u>NONE</u>		<u>HELENA K. PULLMAN</u>		<u>WALGH CHAPEL RD GAMBRIUS</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE (A)				<u>Acute Coronary Thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Generalized Atherosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>1 day</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>2 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>0</u>		<u></u>		<u></u>		<u></u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<u></u>		<u></u>		<u></u>		<u></u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Jan 15 1955</u> to <u>March 15 1955</u>, that I last saw the deceased alive on <u>March 13 1955</u>, and that death occurred at <u>11:00 AM</u>, from the causes and on the date stated above.	
<u></u>		<u></u>		<u></u>		<u></u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>3/18/55</u>		<u>WALGH CHAPEL</u>		<u>WALGH CHAPEL RD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>March 19 1955</u>		<u>Clara Shuford</u>		<u>Wilmington</u>		<u>Delaware</u>	

SIGNATURE

Joseph L. Lippert

M. D.

ADDRESS (Street, city, town, state)

Odenton March 17-55

DATE SIGNED

BURIAL

DATE THEREOF

3/18/55

NAME OF CEMETERY OR CREMATORY

WALGH CHAPEL

LOCATION (City, town, or county)

WALGH CHAPEL RD

(State)

MD

DATE

March 19 1955

REGISTRAR'S SIGNATURE

Clara Shuford

FUNERAL DIRECTOR'S SIGNATURE

Wilmington

ADDRESS

Delaware

BUREAU V. S.

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02278
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH- COUNTY <u>Anne Arundel.</u> MARYLAND		2. BIRTH RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>EARLEIGH Heights.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>EARLEIGH Heights.</u> MD	
OR TOWN <u>EARLEIGH Heights.</u> LENGTH OF STAY (in this place) <u>14 yrs.</u>		OR TOWN <u>EARLEIGH Heights.</u> MD	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gov. Ritchie Hwy.</u>		STREET ADDRESS (If rural, give location) <u>Gov. Ritchie Hwy.</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES Stewart Rennie.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 30 1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>MAY 18, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md.</u>	9. AGE last birthday <u>64</u> yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES Rennie.</u>		14. MOTHER'S MAIDEN NAME <u>ISABELLA Redman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY NO. <u>213-16-5631</u>	
17. INFORMANT AND ADDRESS <u>WIFE</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Heart Failure - myocardi inf.</u>		Antecedent cause(s) (b) <u>Arteriosclerotic C.V. Disease.</u>		7-8 yrs	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Probable Coronary Insufficiency.</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from was not seen alive by me., 1955, to 1955, that I last saw the deceased alive on 1955, and that death occurred at 0900 m., from the causes and on the date stated above.

SIGNATURE <u>Robert D. Hahn</u> (Degree or title)		ADDRESS <u>Severna Park Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>April 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		24. FUNERAL DIRECTOR <u>L. J. Balba</u>		ADDRESS <u>Bar Burns, Md.</u>	
DATE REC'D BY LOCAL REG. <u>April 2, 1955</u>		REGISTRAR'S SIGNATURE			

MARGIN RESERVED FOR BINDING

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

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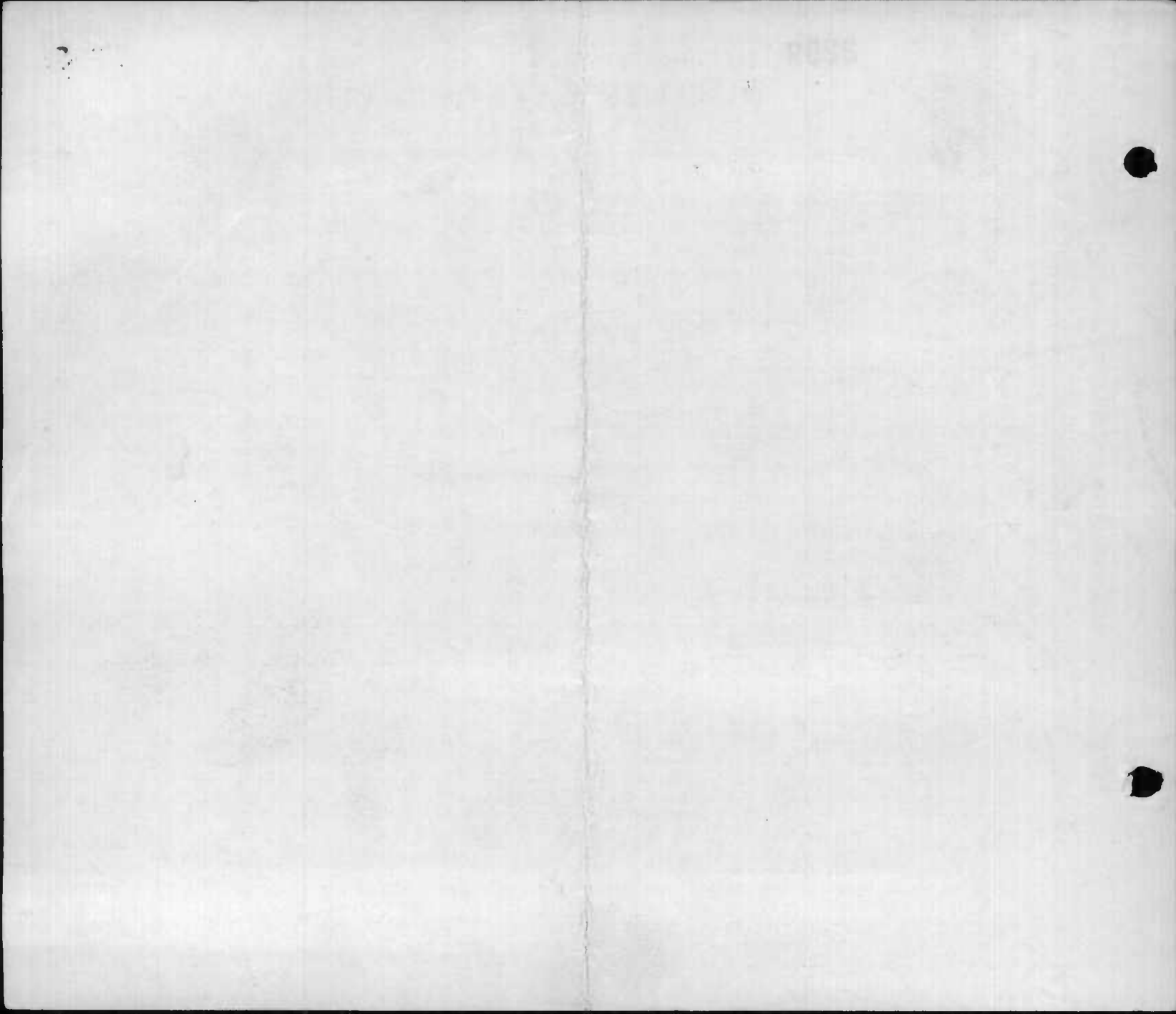
CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH - COUNTY <u>Ellen Burns - D.D. Co. - MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Same</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Ellen Burns -</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
TOWN <u>Ellen Burns -</u>		TOWN <u>Same</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>308 Central Ave. N.W.</u>		STREET ADDRESS (If rural, give location) <u>Same</u>	
3. NAME OF DECEASED (First) <u>Eliza</u> (Middle) <u>M.</u> (Last) <u>Rogan.</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, (WIDOWED) <u>Widowed</u>	8. DATE OF BIRTH <u>6/15/1867</u>
9. AGE last birthday <u>87</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mc Fadden</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Mc Fadden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Dorothy Dunbar - (Daughter)</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>170X Carcinoma of the Vagina & of the Ovary</u>		<u>8 months</u>	
(b) Antecedent cause(s) <u>Carcinoma of the Breast</u>		<u>10 years</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>1945</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of the Breast</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>---</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>James S. Billings Jr. M.D.</u>		DATE SIGNED <u>May 18, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/10/55</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>
DATE REC'D BY LOCAL REG. <u>3/9/55</u>	REGISTRAR'S SIGNATURE <u>A.W. Whitehead</u>	24. FUNERAL DIRECTOR <u>Wm. Cook, Inc., 1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 28

02280

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>				TOWN <u>Gaithersburg</u>		15X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Wallfield Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>Thomas</u> (Last) <u>Ross</u>				Month <u>3</u> Day <u>13</u> Year <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Widower</u>	<u>1860?</u>	<u>85?</u>	Months <u>—</u> Days <u>—</u>	Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter</u>		<u>— — —</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>				<u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				<u>Known to us since</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>				<u>1/19/55</u>			
				<u>" "</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>— — — —</u>		<u>— — — —</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>— — — —</u>		<u>— — — —</u>		<u>— — — —</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>— — — —</u>		<u>— — — —</u>		<u>— — — —</u>			
22. I hereby certify that I attended the deceased from <u>1/19</u> , 19 <u>55</u> , to <u>3/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>55</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wilhelmina Heard Reisman</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>3/18/55</u>		<u>Brook Grove</u>		<u>Lortonville, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>3-14-55</u>		<u>K M Joyce</u>		<u>Robert L. Snowden</u>		<u>Rockville, Md.</u>	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2254

CERTIFICATE OF DEATH

02281

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u>		COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>10 Annapolis</u>		<u>13 Days</u>		TOWN <u>Severn (Rural)</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 A.A. General Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Bonnie</u> (Middle) <u>Lou</u> (Last) <u>Royal</u>				<u>March 6,</u> 19 <u>55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>February 21, 1955</u>	9. AGE last birthday yrs. <u>13</u>	IF UNDER 1 YEAR Months <u>13</u>	IF UNDER 24 HRS. Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Royal</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Mae Wheeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>John Royal, Severn, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>451X</u> IMMEDIATE CAUSE (A) <u>Spina Bi Fida</u>				INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u> <u></u> <u></u> <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>Feb 21</u> , 19 <u>55</u> , to <u>March 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 5</u> , 19 <u>1955</u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>James G. Bennett</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>3-6-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR <u>March 8, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>			

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10. *Journal of the American Medical Association*, 1997; 278: 1019-1024.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

02282

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>10</u> TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u> <u>Weems Creek</u>				STREET ADDRESS (If rural give location) <u>Weems Creek</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> <u>W</u> <u>SEWELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH</u> <u>31</u> <u>19</u> <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 13, 1874</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. Employee</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Sewell</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS <u>Mrs. Rose E. Sewell-Wife- same as # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002X</u> IMMEDIATE CAUSE (A) <u>bilateral pulmonary tuberculosis</u>						<u>??</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/29/54</u> , 19....., to <u>3/31/55</u> , 19....., that I last saw the deceased alive on <u>3/30/55</u> 19....., and that death occurred at <u>10:40PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. Bornick</u>		M. D. <u>Annapolis, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>4/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 4, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>April 4, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOIS, MD</u>	

02588

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

2588

DATE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

APR 6 1915

RECEIVED

INDICATIONS

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02283

2256

CERTIFICATE OF DEATH

Item 9, Film 180 4-20-55 et

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA Co</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA Co</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>10 ANNA POLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNA POLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 90 CALVERT ST</u>				STREET ADDRESS (If rural give location) <u>90 CALVERT ST</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ESTELLA BATSON STANTON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 9th 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-23-1905</u>	9. AGE last birthday <u>49 yrs.</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER STERENS</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR BATSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>ELEANOR JOHNSON 90 CALVERT ST</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
44.2x IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-renal disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>10:10 PM</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 7, 1955</u> , to <u>March 9, 1955</u> , that I last saw the deceased alive on <u>March 7, 1955</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. R. H. Jones</u>		M.D. <u>Dr. R. H. Jones</u>		ADDRESS (Street, city, town, state) <u>110 E. 10th St</u>		DATE SIGNED <u>3/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Drewry Hill</u>		LOCATION (City, town, or county) (State) <u>ANNAPOLIS, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II</u>		ADDRESS <u>108 Washington St</u>	
DATE <u>3-10-55</u>						<u>ANNAPOLIS, MD</u>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 18
8235 CERTIFICATE OF DEATH

BUREAU V. S.

MAR 11 1931

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02284

2257 CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 14. Film GL79 3-18-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY A.A. Co		MARYLAND		STATE Md.		COUNTY A.A. Co.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis, Md.		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis, Md.		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1316 Bay Ridge Ave.				STREET ADDRESS (If rural give location) 1316 Bay Ridge Ave.		1	
3. NAME OF DECEASED (Type or Print) JOHN		(First) (Middle) E.		(Last) STOKES SR.		4. DATE OF DEATH 3 7 19 55	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 20, 1877	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodwork		10b. KIND OF BUSINESS OR INDUSTRY Cabinet Maker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Stokes				14. MOTHER'S MAIDEN NAME Mary Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Richard Stokes #2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) Cerebral Vascular Accident						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic CVD						yes	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Benign prostatic Hypertrophy						yes	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/31/55, to 3/17, 1955, that I last saw the deceased alive on 3/16/55, and that death occurred at 11:15 PM, from the causes and on the date stated above.							
SIGNATURE Frank M. Shipley		DATE THEREOF 3/10/55		NAME OF CEMETERY OR CREMATORY Cedar Bluff		LOCATION (City, town, or county) (State) Annapolis, Md.	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR March 9, 1955		25. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor and Sons		ADDRESS Annapolis, Md.	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02285

2301

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>-- Route 1, Box 372</u>				STREET ADDRESS (If rural give location) <u>Route 1, Box 372</u>			
3. NAME OF DECEASED: (First) <u>JAMES</u> (Middle) <u>P.</u> (Last) <u>STRONG, Sr.</u>				4. DATE OF DEATH: (Month) <u>Mar.</u> (Day) <u>1</u> (Year) <u>19 55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Sept. 24, 1885</u>	
9. AGE last birthday: <u>69</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Brakeman (rtd) Railroad</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Earl R. Strong</u>				14. MOTHER'S MAIDEN NAME: <u>Anne Phillips</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs. Carrie C. Strong - Pasadena, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Acute coronary thrombosis</u>						<u>8 hours</u>	
Antecedent causes (s) (b) <u>Coronary insufficiency</u>						<u>5 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS						3 years	
Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arthritis</u>							
19a. DATE OF OPERATION: <u>0</u>						19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)						22. AUTOPSY ?	
PLACE (Home, farm, factory, street, office bldg., etc.)						Yes <input type="checkbox"/> No <input type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY							
INJURY OCCURRED							
While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>							
HOW DID INJURY OCCUR ?							
22. I hereby certify that I attended the deceased from <u>April 5, 1954</u> , to <u>March 1, 1955</u> , that I last saw the deceased alive on <u>Feb. 28, 1955</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. M. McLaughlin, M.D.</u>				ADDRESS <u>Pasadena, Md.</u> DATE SIGNED <u>March 1, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/4/55</u>		<u>Loudon Park Cem.</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-2-55</u>		<u>R. M. McLaughlin</u>		<u>Wm. J. Trepanier & Sons</u>		<u>Balto. 17, Md.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2392

CERTIFICATE OF DEATH

02286

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>34 yrs. 4 mos. 9 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED (Type or Print) <u>Mamie</u> (First) <u>Taylor</u> (Last)				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>5</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1887?</u>	9. AGE last birthday <u>67?</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jerry Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>443X</u> IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						<u>Progressively present since adm. 10/27/20</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Hypertensive arteriosclerosis</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION <u> - - -</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u> - - -</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> - - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u> - - -</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> - - -</u>			
22. I hereby certify that I attended the deceased from <u>1/21</u> , 19 <u>48</u> , to <u>3/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>55</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Crownsville, Md.</u>		DATE SIGNED <u>3/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u> - - -</u>		DATE THEREOF <u>3/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Crownsville State Hospital</u>		LOCATION (City, town, or county) (State) <u>Crownsville Md</u>	
24. REC'D BY REGISTRAR <u>3-17-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Crownsville, Md.</u>	

CERTIFICATE OF DEATH

Form No. 10-1

1. Usual Residence (Name of Deceased)

2. Date of Death

3. Place of Death

4. Cause of Death

5. Manner of Death

6. Age at Death

7. Sex

8. Race

9. Marital Status

10. Occupation

11. Education

12. Date of Birth

13. Date of Admission to Hospital

14. Date of Discharge from Hospital

15. Date of Death

16. Date of Burial

17. Date of Interment

18. Date of Cremation

19. Date of Disposition

20. Date of Final Disposition

21. Date of Final Disposition

22. Date of Final Disposition

23. Date of Final Disposition

24. Date of Final Disposition

25. Date of Final Disposition

26. Date of Final Disposition

27. Date of Final Disposition

28. Date of Final Disposition

29. Date of Final Disposition

30. Date of Final Disposition

BUREAU V. S.

MAR 22 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2303

CERTIFICATE OF DEATH

02287

28

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>16 yrs. 9 mos.</u>		CITY (If outside corporate limits, write RURAL end give nearest town) <u>Baltimore City</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1507 N. Calhoun Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Rufus</u> (First) <u>Taylor</u> (Middle) <u>Taylor</u> (Last)				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>1892?</u>	9. AGE last birthday <u>62?</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Delia Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Cardio-vascular Disease</u>						Known to us since <u>12/25/54</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <u> </u> at work <u> </u>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>1/21</u> , 19 <u>48</u> , to <u>3/2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/2</u> , 19 <u>55</u> , and that death occurred at <u>4:15 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D.		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>3/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>University Hospital</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>3-7-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>4401 E. 1st St.</u>	

CERTIFICATE OF DEATH

State of Maryland

County of Baltimore

City of Baltimore

Ward of Baltimore

Block of Baltimore

Lot of Baltimore

House of Baltimore

Room of Baltimore

Apartment of Baltimore

Condo of Baltimore

Trailer of Baltimore

Mobile home of Baltimore

Other of Baltimore

Address of Baltimore

City of Baltimore

State of Maryland

County of Baltimore

City of Baltimore

Ward of Baltimore

Block of Baltimore

Lot of Baltimore

House of Baltimore

Room of Baltimore

Apartment of Baltimore

Condo of Baltimore

Trailer of Baltimore

Mobile home of Baltimore

Other of Baltimore

Address of Baltimore

City of Baltimore

State of Maryland

County of Baltimore

City of Baltimore

Ward of Baltimore

Block of Baltimore

Lot of Baltimore

BUREAU V. S.

MAR 10 1955

RECEIVED

NOT RECORDED

2258

02288

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Annapolis, Md</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Wardour Annapolis Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>		STREET ADDRESS (If rural, give location) <u>208 Norwood Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Josephine Stafford Thomas</u>		4. DATE OF DEATH <u>Mar. 12</u> 19 <u>53</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>	8. DATE OF BIRTH: <u>Sept 18 60</u>
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>house wife</u>		9b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>94</u> yrs.
10. CITIZEN OF WHAT COUNTRY?		11. BIRTHPLACE (State or foreign country): <u>Urbania Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs Martha C. Stent, 208 Norwood Rd</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
493X Immediate cause (a) <u>Pneumonia</u>			<u>Feb 8, 53</u> <u>1 mo plus</u>
Antecedent cause(s) (b) <u>Fracture left hip</u>			
Diseases or conditions, if any, giving rise to the above cause (c) <u>Fall in her home</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>			
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: <u>Feb 8, 1953</u> <u>Comminuted intertrochanteric fracture left hip</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	21c. (City or town) (County) <u>above address</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 8</u> <u>53</u> <u>12 A.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Slipped going to bath</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Harold R. Bohlerman</u>		M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>	DATE THEREOF <u>3/15/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem</u>	LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>
DATE REC'D BY LOCAL REG. <u>3/14/55</u>	REGISTRAR'S SIGNATURE <u>G. W. H. H. H.</u>	24. FUNERAL DIRECTOR <u>Barton Sons Catonsville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C. 20315

DATE: 10/10/68

TO: THE SECRETARY OF THE ARMY

FROM: THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02289
2304 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundal</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Pasadena</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Pasadena</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 Doris Ave.</u>				STREET ADDRESS <u>1 Doris Ave.</u>		(If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Thomson</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>March 12 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>8/23/1903</u>	
9. AGE last birthday: <u>51</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Grocery</u>		11. BIRTHPLACE (State or foreign country): <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>Salesman</u>				11. BIRTHPLACE (State or foreign country): <u>Scotland</u>			
13. FATHER'S NAME: <u>Walter Thomson</u>				14. MOTHER'S MAIDEN NAME: <u>M.C. McCracken</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>716-07-5865</u>		17. INFORMANT & ADDRESS: <u>Mary T. Thomson 1 Doris Ave. Pasadena Md.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of stomach</u>		<u>6 months</u>
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from Oct. 2, 1954, to Mar. 12, 1955, that I last saw the deceased alive on Mar. 12, 1955, and that death occurred at 8:25 a.m., from the causes and on the date stated above.

SIGNATURE R. M. McLaughlin M.D. ADDRESS Pasadena, Md. Mar. 12, 1955 DATE SIGNED

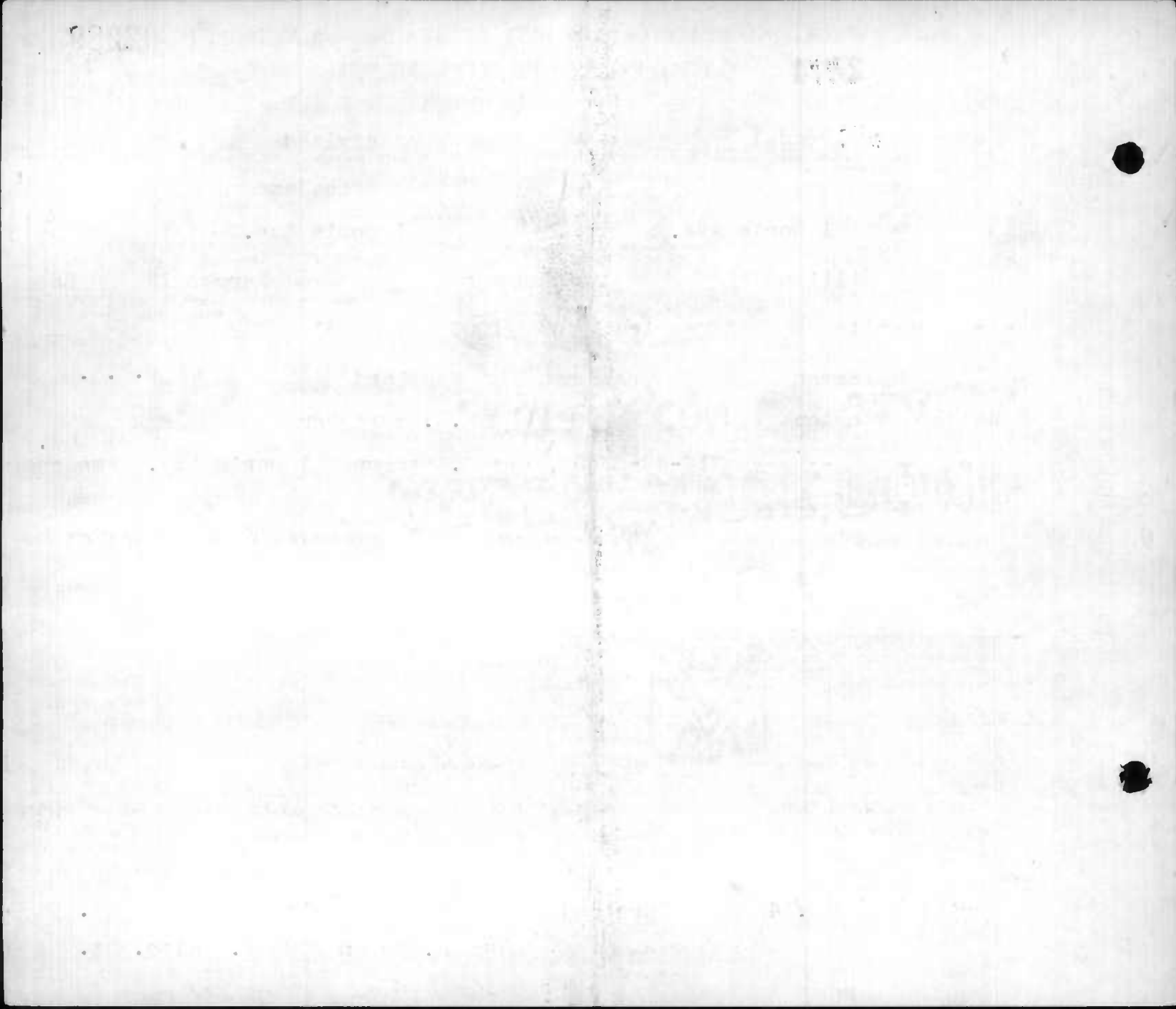
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Burial 10/31/55 NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE John A. Moran 24. FUNERAL DIRECTOR ADDRESS 3000 E. Balto. St.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2305

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02290

Reg. Dist. No. 22

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Town</u> <u>Laurel R.F.D.</u> LENGTH OF STAY (in this place) <u>5 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Town</u> <u>Laurel</u> <u>Md</u> <u>16-41-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main st</u>		STREET ADDRESS (If rural, give location) <u>Main st</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>HARRY CLEVERLAND WHITEHEAD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 20 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 17, 1885</u> 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SKILLED LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laurel Md</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
13. FATHER'S NAME <u>Jacob Whitehead</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Merson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-14-16-73</u>	
17. INFORMANT AND ADDRESS <u>Flora Merson Laurel R.F.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Cornary occlusion</u>			4 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertension, acute Bronchitis</u>			1 yr +
(c) <u>Hypertension & heart disease</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0 -</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
(CITY OR TOWN) <u>Laurel</u> (COUNTY) <u>Md</u> (STATE) <u>Md</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Mar 20 1955</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>314 Confr an Laurel rd</u>			
22. I hereby certify that I attended the deceased from <u>3/17</u> , 19 <u>55</u> , to <u>3/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 20</u> , 19 <u>55</u> , and that death occurred at <u>8:20</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Dr B. M. Merson</u>		ADDRESS <u>314 Confr an Laurel rd</u> DATE SIGNED <u>3/21/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar 23, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Mary Hill</u>		LOCATION (City, town, or county) <u>Laurel</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>Mar 22-55</u>		24. FUNERAL DIRECTOR <u>W. R. Ridgely Selby</u> ADDRESS <u>401 Wash Ave Laurel Md</u>	

RECEIVED

MAR 23 1965

BUREAU V. S.

1

INSTRUCTIONS

1 The bottom copy may be retained by the hospital or attending physician.
TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within **24 hours** after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 113C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2306

CERTIFICATE OF DEATH

02291
24

Reg. Dist. No.....

1. PLACE OF DEATH Anne ARUNDEL COUNTY MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY			
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X GLEN BURNIE 2 months		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 PLAZA MANOR COVALESCENT HOME, Route 2 Box 376A		STREET ADDRESS 1303 Bloomingdale Rd.		DATE (Month) (Day) (Year) March 8 1955		4. DATE OF DEATH	
3. NAME OF DECEASED (Type or Print) (First) BESSIE (Middle) WILLIAMS (Last)				4. DATE OF DEATH			
5. SEX F		6. COLOR OR RACE C		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH July 14, 1892 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bundy				14. MOTHER'S MAIDEN NAME Emma Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Albert Bundy			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) Septicemia, Kochexia.				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Diabetes mellitus and							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Multiple abscesses of							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Skin & gangrene							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/15, 1955, to 3/5, 1955, that I last saw the deceased alive on 3/5, 1955, and that death occurred at 10 P.M. from the causes and on the date stated above.							
SIGNATURE Joseph Taler				ADDRESS (Street, city, town, state) 102 Baltimore - Annapolis Blvd. Glen Burnie Md.		DATE SIGNED 3/8/1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 11/55		NAME OF CEMETERY OR CREMATORY Mt Calvary Cem		LOCATION (City, town, or county) (State) A. A. County Md	
24. REC'D BY REGISTRAR DATE 3/11/55		REGISTRAR'S SIGNATURE A. W. Hedrick		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Robert A. Elliott & Daughter		ADDRESS 11299 Carolina St	

CERTIFICATE OF DEATH

3838

DATE OF DEATH

PLACE OF DEATH

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4,188 22

BUREAU V. S.

MAR 11 1955

RECEIVED

1
I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the files of the Bureau of Vital Statistics, State of Maryland, and that the same has been compared with the original and found to be correct.
J. H. HARRIS, Director
Bureau of Vital Statistics
State of Maryland
Baltimore, Maryland

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2259

CERTIFICATE OF DEATH

02292
21

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				OR TOWN <u>Riva</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>Sylvan Shores</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELAINE</u> (Middle) <u>WALLIS</u> (Last) <u>WILSON</u>				(Month) <u>MARCH</u> (Day) <u>11</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>December 17, 1936</u>	<u>18 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Dentist attendant</u>		<u>Dentist's office</u>		<u>Worcester, Massachusetts</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Dr. John N. Wilson</u>				<u>Wilma V. Vierbucken</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>212-34-1823</u>			
				<u>Mrs Wilma Wilson- Mother- same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
541.0 IMMEDIATE CAUSE (A)				<u>Acquired Hemolytic Anemia</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Perforated Peptic Ulcer</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-7</u> , 19 <u>55</u> , to <u>3-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-11-55</u> , 19 <u>55</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward A. Beck</u>				ADDRESS (Street, city, town, state) <u>411 Southgate Ave Annapolis</u>			
DATE <u>3-14-55</u>				DATE SIGNED <u>3/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>3-14-55</u>		<u>New Cathedral Cemetery</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>March 14, 1955</u>		<u>Jo - O. Daniel</u>		<u>B.L. Hopping and Son</u>		<u>Annapolis, Md.</u>	

CERTIFICATE OF DEATH

3928

NAME OF DECEASED John H. Wilson		AGE 45		SEX Male	
DATE OF DEATH December 10, 1955		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 3928	
SIGNATURE OF PHYSICIAN J. H. Wilson		SIGNATURE OF DECEASED John H. Wilson		SIGNATURE OF WITNESS J. H. Wilson	
DATE OF SIGNATURE December 10, 1955		PLACE OF SIGNATURE Home		CITY Baltimore	

BUREAU V. 3

MAR 15 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02293

2307

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Crownsville</u>		<u>55 days</u>		OR TOWN <u>Cockeysville</u>		<u>03X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Almshouse</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>James Henry Winder</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 26 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>Unk.</u>	9. AGE last birthday <u>70?</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Winder</u>				14. MOTHER'S MAIDEN NAME <u>Frances</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 days	
025X IMMEDIATE CAUSE (A) <u>Lobar Pneumonia</u>						known to us	
ANTECEDENT CAUSE(S) DUE TO						since 2/1/55	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>C.N.S. Syphilis, Meningoencephalitis</u>							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. -----							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? -----			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 1955, to <u>3/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/26</u> , 1955, and that death occurred at <u>2:00</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict, MD</u>		ADDRESS (Street, city, town, state) <u>Crownsville, Md</u>		DATE SIGNED <u>3/26/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery, Baltimore, Md</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
24. REC'D BY REGISTRAR <u>March 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Therese M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. D. Hensley</u>		ADDRESS <u>W. D. Hensley, 511 E. Pratt St.</u>	

BUREAU V. S.
MAR 2

RECEIVED
MAR 29 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2308

02294

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Millersville, Md.</u>		<u>8 months</u>		TOWN <u>Baltimore</u>		<u>31 3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SANN'S NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>348 BALLOU COURT</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Bertha</u> (Middle) <u>WOLF</u> (Last)				<u>MARCH 7, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>WIDOWED</u>	<u>Feb 5, 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>OWN Home</u>		<u>Baltimore, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Brandt</u>				<u>(UNK)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>				<u>HARRY C. WOLF, SR. Glen Burnie, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>443X</u> IMMEDIATE CAUSE (A) <u>Hypertensional Cardio-Vascular disease</u>						<u>+ 8 months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 8, 1955</u>, to <u>March 7, 1955</u>, that I last saw the deceased alive on <u>March 4, 1955</u>, and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Rebecca K. Buckner, M.D.</u>				<u>Glen Burnie, Md.</u>		<u>3/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/10/55</u>		<u>Glen Haven</u>		<u>Glen Burnie Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>3-10-55</u>		<u>K M Joyce</u>		<u>Hopping & Kirkley, Glen Burnie Md</u>			

45508

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

2388

LEGAL REPRESENTATIVE OF DECEASED

PLACE OF DEATH

MARRIED

COUNTY

PLACE OF DEATH

PLACE OF DEATH

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UNRECORDED

BUREAU V. S.

MAR 14 1955

RECEIVED

THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED OR BY THE ATTENDING PHYSICIAN OF THE HOSPITAL OR BY THE CORONER OR BY THE JURY IN CASE OF SUICIDE OR BY THE JURY IN CASE OF DEATH BY UNNATURAL CAUSE. IT IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED OR BY THE ATTENDING PHYSICIAN OF THE HOSPITAL OR BY THE CORONER OR BY THE JURY IN CASE OF SUICIDE OR BY THE JURY IN CASE OF DEATH BY UNNATURAL CAUSE. IT IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED OR BY THE ATTENDING PHYSICIAN OF THE HOSPITAL OR BY THE CORONER OR BY THE JURY IN CASE OF SUICIDE OR BY THE JURY IN CASE OF DEATH BY UNNATURAL CAUSE.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2309

02295

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A A</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A A</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
<u>SEVERN (RURAL)</u>				<u>SEVERN (RURAL)</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>Quarterfield Rd. 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
<u>Herbert</u>				<u>Wolf</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>OCT. 13, 1886</u>	
						9. AGE last birthday <u>68</u> yrs.	
						IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				<u>RAILROAD</u>		<u>MARYLAND</u>	
13. FATHER'S NAME <u>AUGUST WOLF</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Nickolson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>				<u>213-03-6993</u>		<u>Roy Wolf, Severn, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
592x IMMEDIATE CAUSE (A) <u>Chronic Mitral Insufficiency</u>						<u>+ 3 years.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Interstitial Nephritis</u>						<u>+ 3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January</u> , 19 <u>51</u> , to <u>March 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>55</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Paulsen MD</u>				ADDRESS (Street, city, town, state) <u>Melen Busck, Md.</u>		DATE SIGNED <u>3/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/14/55</u>		<u>Friend ship</u>		<u>A. A. Co.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>4/16-55</u>		<u>Alana Hoasler</u>		<u>Hopping + Kirkley</u>		<u>Glen Burnie Md.</u>	

RECEIVED